

Alex R. Straus, Esq., CA Bar No.: 321366  
[astraus@milberg.com](mailto:astraus@milberg.com)  
*Attorney for Plaintiff*  
MILBERG COLEMAN BRYSON  
PHILLIPS GROSSMAN, PLLC  
280 S. Beverly Drive, Penthouse, Beverly Hills, CA 90212  
Tel.: (919) 600-5000 / Fax: (919) 600-5035

**UNITED STATES DISTRICT COURT  
CENTRAL DISTRICT OF CALIFORNIA**

**SERIES 15-09-321, a Delaware entity,**

**Plaintiff,**

**v.**

**FARMERS INSURANCE EXCHANGE;  
MIDCENTURY INSURANCE COMPANY;  
21<sup>st</sup> CENTURY CENTENNIAL COMPANY;  
FOREMOST INSURANCE COMPANY  
GRAND RAPIDS, MICHIGAN; FARMERS  
INSURANCE COMPANY, INC.; and FARMERS  
INSURANCE COMPANY OF WASHINGTON**

**Defendants.**

**Case No.:**

**JURY TRIAL  
DEMAND**

**COMPLAINT**

Plaintiff, Series 15-09-321 brings this action against Farmers Insurance Exchange, Mid-Century Insurance Company, and 21<sup>st</sup> Century Foremost Insurance Company Grand Rapids, Michigan, and Farmers Insurance Company, Inc., and Farmers Insurance Company of Washington (singularly “Defendant” and collectively, “Defendants”), and alleges:

## INTRODUCTION

1  
2           1.     The Medicare program spent \$756 billion (roughly 12% of the  
3     entire federal budget) in fiscal year 2022 to provide health insurance for  
4     roughly 65 million people (around 20% of the U.S. population) who are aged  
5     65 and older or have disabilities. With the aging population expected to become  
6     nearly a quarter of the U.S. population by 2060 (95 million people), one of  
7     Medicare’s main trust funds is expected to run dry by 2028.<sup>1</sup> For these reasons,  
8     identifying and correcting fraud, waste, and abuse—and ensuring the Medicare  
9     pays only for bills Congress intended to pay—is more important now than ever  
10    before to ensure the long-term sustainability of an essential federal program  
11    that has been in existence since 1965.

12           2.     More than 40 years ago, in 1980, Congress first addressed fears  
13    regarding Medicare insolvency by passing with overwhelming bipartisan  
14    support the Medicare Secondary Payer Act (the “MSP Act”). The intent of the  
15    MSP Act was to staunch the tide of “ballooning medical entitlement costs.”  
16    *Netro v. Greater Baltimore Med. Ctr., Inc.*, 891 F.3d 522, 524 (4th Cir. 2018).

---

<sup>1</sup><https://www.whitehouse.gov/briefing-room/statements-releases/2023/03/07/fact-sheet-the-presidents-budget-extending-medicare-solvency-by-25-years-or-more-strengthening-medicare-and-lowering-health-care-costs/> (last visited October 1, 2023) (“[T]he most recent Medicare Trustees Report projected that the HI Trust Fund would be insolvent in 2028 . . . .”). The HI Trust Fund provides funding for Medicare Part A services, such as hospital stays.

1 Prior to the MSP Act, Medicare paid for all medical treatment within its scope  
2 and left private insurers merely to pick up whatever expenses remained. With  
3 the MSP Act, Congress mandated that auto insurers like Defendants—rather  
4 than Medicare—would become primarily responsible for medical expenses  
5 covered by their insurance policies.

6 3. Instead of allowing insurers to accept premiums from their  
7 policyholders and then sit back while Medicare paid medical bills covered by  
8 the insurers' policies, Congress mandated that the insurers would be primary  
9 payers and Medicare would simply provide a safety net for its beneficiaries in  
10 the event the insurance carriers did not promptly pay. In short, Congress  
11 intended through the MSP Act to transfer the cost and financial burden of  
12 healthcare to private insurance plans who were receiving premiums expressly  
13 intended to cover the medical expenses being paid by Medicare prior to the  
14 MSP Act. Congress enacted section 1395y(b)(1) to reduce federal expenditures  
15 by making private automobile insurers primarily liable for the cost of servicing  
16 their policies.

17  
18 4. Subsequently, when Congress created the Medicare Advantage  
19 option under Part C of Medicare, 42 U.S.C. § 1395w-21(a)(1)(B), it ensured

1 that Medicare Advantage Organizations (“MAOs”), just like Medicare, would  
2 be deemed the *secondary payer* when the Medicare beneficiaries’ medical  
3 expenses are covered concurrently by other insurance policies. 42 U.S.C. §  
4 1395w-22(a)(4). Medicare Part C permits Medicare beneficiaries to choose to  
5 receive their health care benefits from private insurers through MAOs. As of  
6 June 2023, over 31 million individuals—nearly 40% of all Medicare  
7 beneficiaries—had elected to enroll with an MAO and participate in a Medicare  
8 Advantage Plan (“MA Plan”).<sup>2</sup>

9         5. To protect Medicare beneficiaries, Congress authorizes both  
10 Medicare and MAOs to go ahead and pay a beneficiary’s medical expenses first  
11 when a primary player has not made or cannot reasonably be expected to make  
12 payment promptly. 42 U.S.C. § 1395y(b)(2)(B)(i). Such payments are  
13 “intended to minimize patient anxiety about the source of payment and to avoid  
14 delays in reimbursement for” medical expenses. H.R. Rep. No. 97-208, pt. 2,  
15 at 956 (1981) However, under the MSP Act, Medicare’s and the the MAO’s  
16 payment is conditioned on the primary payer—the insurer—ultimately  
17 reimbursing Medicare and the MAO. 42 U.S.C. § 1395y(b)(2)(B)(ii). In this

---

<sup>2</sup> Monthly Contract and Enrollment Summary Report, Ctrs. For Medicare & Medicaid  
Servs., <https://www.cms.gov/ResearchStatistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Contract-and-Enrollment-Summary-Report>  
(last visited October 1, 2023)

1 way, Medicare beneficiaries receive the health care they need, but Medicare  
2 remains entitled to reimbursement.

3           6.       When Medicare or an MAO makes a payment that a primary plan  
4 was responsible for, the payment is conditional. This rule applies any time an  
5 insurer contests liability at the time of the Medicare or MAO payment, or even  
6 where Medicare or the MAO paid for a medical expense simply because it “did  
7 not know that the other coverage existed.” 42 C.F.R. § 411.21.

8           7.       To ensure that Medicare would be reimbursed, Congress provided  
9 the United States government a cause of action to obtain reimbursement from  
10 a primary plan. *See* 42 U.S.C. § 1395y(b)(2)(B)(iii). When that addition proved  
11 insufficient to ensure primary payers such as insurance carriers were  
12 reimbursing Medicare, Congress enacted a private cause of action so that  
13 persons and private entities could recover conditional payments made by  
14 Medicare (and, later on, MAOs) when insurers failed to reimburse Medicare  
15 and MAOs for the payments made for expenses that were covered by their  
16 insurance policies. Congress provided for double damages so that private  
17 litigants would be incentivized to pursue a recalcitrant insurer. This has  
18 become even more important as each year that passes more Medicare  
19 beneficiaries are opting for Medicare Part C.

1           8. Compliance with the MSP Act should lead to tremendous savings  
2 for the Medicare program. In 2021, minimal compliance by primary payers  
3 resulted in approximately \$9.7 billion in savings. However, that's just the tip  
4 of the iceberg. According to an industry white paper, approximately 8 to 10%  
5 of all healthcare expenditures are related to some type of accident.<sup>3</sup> When a  
6 Medicare beneficiary is involved in an automobile accident, the beneficiary  
7 will almost always be insured for medical expenses either under the  
8 beneficiary's own auto insurance policy or under the policy of another driver.  
9 However, as authorized by the MSP Act, Medicare frequently ends up  
10 conditionally paying the privately covered medical expenses first. Accordingly,  
11 with expenditures over \$700 billion, one should expect Medicare and MAOs to  
12 be able to recover at least something within range of 8% expenditures, which  
13 would amount to tens of billions of dollars. Recoveries, however, are not even  
14 remotely close to those amounts because auto insurers have systematically  
15 disregarded their duty to comply with their obligations under the MSP Act.<sup>4</sup>

---

<sup>3</sup> <https://www.optum.com/content/dam/optum3/optum/en/resources/white-papers/StrengtheningPaymentIntegrity-SubrogationInjuryCoverageWhitePaper.pdf>, p. 2 (last visited October 1, 2023).

<sup>4</sup> [https://www.tucsonsentinel.com/opinion/report/043023\\_gonzales\\_medicare\\_op/gonzales-pursuing-more-insurance-reimbursements-would-bolster-medicare-funding/](https://www.tucsonsentinel.com/opinion/report/043023_gonzales_medicare_op/gonzales-pursuing-more-insurance-reimbursements-would-bolster-medicare-funding/) (last visited October 1, 2023) (opinion piece by Arizona State Senator Sally Gonzales observing that the insurance industry is "costing taxpayers billions yearly and putting Medicare at risk" and the MSP Act should be vigorously enforced "so that Medicare has the funding that it needs.").

1           9.     Through years of investigation, including sending thousands of  
2     coordination of benefits letters to auto insurers across the country, Plaintiff has  
3     uncovered two strategies adopted by insurers that have contributed to the  
4     depletion of Medicare's trust funds by enabling insurers to evade their primary  
5     payer obligations. First, auto insurers, including Defendants, have done very  
6     little to identify or coordinate with MAOs who have made conditional  
7     payments, much less reimburse them. Those MAOs are ultimately funded from  
8     the same trust funds as Medicare.

9           10.    Second, auto insurers, including Defendants, fail to properly  
10    report to Medicare their primary payer status and related information as  
11    mandated by Section 111 of the Medicare, Medicaid, and SCHIP Extension Act  
12    of 2007, PL 110-173 ("Section 111 reporting"). Through Section 111, on a  
13    quarterly basis, insurers are supposed to share data with Medicare that allows  
14    Medicare to determine whether it made a secondary payment that was in fact  
15    the responsibility of another insurer—the primary payer. However, auto  
16    insurers, including the Defendants, fail to gather the necessary Medicare  
17    information from the injured person or act on the data contained in bills sent to  
18    insurers by healthcare providers and, therefore, do not submit the information  
19    to Medicare as mandated by Section 111. This failure is either due to insurers,

1 including the Defendants, having flawed systems and faulty data or represents  
2 a purposeful effort by them to hide the insurers' primary status from Medicare  
3 and MAOs. Without a proper Section 111 report, Medicare—and ultimately  
4 MAOs—frequently do not know that they are secondary payers and do not  
5 know who the primary payer is.

6 11. The auto insurers' strategies, including those of the Defendants,  
7 have harmed and will continue to harm Medicare and MAOs across the  
8 country. The Ninth Circuit in *DaVita Inc. v. Virginia Mason Mem'l Hosp.*, 981  
9 F.3d 679, 692 (9th Cir. 2020), observed: "It may seem implausible today that  
10 [an insurance] plan would blatantly contradict the MSP by asserting that  
11 Medicare must pay first. But we note that, for decades, the sole purpose of the  
12 MSP was to require private plans to pay first—a requirement that insurers  
13 resisted and that Congress struggled to enforce." Even now, insurers like the  
14 Defendants continue to resist.

15 12. For that reason, this action seeks to enforce the MSP Act through  
16 the Act's private cause of action—enacted specifically to overcome insurers'  
17 resistance—by requiring the Defendants to do what the MSP Act Mandates:  
18 identify and reimburse conditional payments made by one of the largest MAOs  
19 in the country when Defendants were the primary payer. That MAO ("the MAO

1 assignor”) assigned its conditional payment recovery rights to Plaintiff to bring  
2 this action.

3 **PARTIES, JURISDICTION, AND VENUE**

4 13. Plaintiff Series 15-09-321 is a Delaware series limited liability  
5 company with a principal place of business located at 2701 S. Le Jeune Road,  
6 10th Floor, Coral Gables, Florida 33134. Series 15-09-321 is the ultimate  
7 assignee of the MAO Assignor’s rights to recovery.

8 14. Defendant Farmers Insurance Exchange is an insurer that issues  
9 liability and no-fault policies, with its principal place of business at 6301  
10 Owensmouth Ave, Woodland Hills, California, United States. At all material  
11 times, Farmers Insurance Exchange was and is authorized and licensed to  
12 transact insurance in the State of California.

13  
14 15. Defendant Mid-Century Insurance Company is an insurer that  
15 issues liability and no-fault policies, with its principal place of business at 6301  
16 Owensmouth Ave, Woodland Hills, California, United States. At all material  
17 times, Mid-Century Insurance Company was and is authorized and licensed to  
18 transact insurance in the State of California.

19 16. Defendant 21<sup>st</sup> Century Centennial Insurance Company is an

1 insurer that issues liability and no-fault policies, with its principal place of  
2 business at 3 Beaver Valley Road, Wilmington, Delaware, United States. At all  
3 material times, 21<sup>st</sup> Century Centennial Insurance Company was and is  
4 authorized and licensed to transact insurance in the State of California.

5 17. Defendant Foremost Insurance Company Grand Rapids, Michigan  
6 is an insurer that issues liability and no-fault policies, with its principal place  
7 of business at 5230 33RD St SE Grand Rapids, Michigan, United States. At all  
8 material times, Foremost Insurance Company Grand Rapids, Michigan was and  
9 is authorized and licensed to transact insurance in the State of California.

10 18. Defendant Famers Insurance Company, Inc., is an insurer that  
11 issues liability and no-fault policies, with its principal place of business at 6301  
12 Owensmouth Ave, Woodland Hills, California, United States. At all material  
13 times, Famers Insurance Company, Inc., was and is authorized and licensed to  
14 transact insurance in the State of California.

15 19. Defendant Farmers Insurance Company of Washington, is an  
16 issuer that issues liability and no-fault policies. At all material times, Farmers  
17 Insurance Company of Washington was and is authorized and licenses to  
18 transact insurance in the State of California.

19 20. This Court has jurisdiction over the subject matter of this action

1 under 28 U.S.C. § 1331.

2  
3 21. Venue is proper in this District pursuant to 28 U.S.C. §1391 (b),  
4 (c), and (d) because at all times material hereto, Defendants resided, transacted  
5 business, were found, or had agents in this District, and a substantial portion of  
6 the alleged activity affecting trade and commerce discussed below has been  
7 carried out in this District.

8 22. This Court has personal jurisdiction over Defendants because  
9 Defendants are at home in this forum, and personal jurisdiction over  
10 Defendants does not offend traditional notions of fair play and substantial  
11 justice.

12 **THE MEDICARE ADVANTAGE PROGRAM**

13 23. Medicare enrollees may elect to receive their benefits in own of  
14 two ways. First, they may receive their benefits under the traditional Medicare  
15 Parts A and B. Known as the Medicare “fee for service” option Parts A and B  
16 provide hospital insurance and coverage for medically necessary outpatient and  
17 physician services. 42 U.S.C. § 1395w-21(a)(1)(A). Under Parts A and B,  
18 government contractors pay for Medicare enrollees’ expenses directly on a fee-  
19 for-service basis. Alternatively, under Medicare Part C, Medicare enrollees

1 may receive their Medicare benefits from private health insurers called  
2 Medicare Advantage Organizations or MAOs. 42 U.S.C. § 1395w-21(a)(1)(B).

3         24. Congress enacted the Part C “Medicare Advantage” option in  
4 1997 after experts had come to realize that the Parts A and B “fee for service”  
5 payment structure encouraged healthcare providers to order more tests and  
6 procedures than medically necessary. Through Medicare Advantage, Congress  
7 intended to “enable the Medicare program to utilize innovations that have  
8 helped the private market contain costs and expand health care delivery  
9 options.” H.R. Rep. No. 105-217, at 585 (1997) (Conf. Rep.).  
10

11         25. Each MAO contracts individually with the Secretary of Health and  
12 Human Services. 42 U.S.C. § 1395w-27. Under that contract, the MAO  
13 receives a fixed amount per enrollee based on the plan’s enrollees’ risk factors  
14 and other characteristics rather than payment of a fee for specific services  
15 performed. The MAO must then provide at least the same level of benefits that  
16 enrollees would receive under the fee-for-service Medicare Plan A and B  
17 option. *See id.* at § 1395w-22. By paying MAOs a fixed amount per enrollee—  
18 called a “capitation” payment system—Congress sought to safeguard public  
19 dollars while improving the quality of care.

1           26. Under a capitation-based system, the MAO provides Medicare  
2   benefits in exchange for the fixed monthly fee per person enrolled in the  
3   program regardless of actual healthcare usage. MAOs are thus incentivized to  
4   provide health insurance more efficiently than under the fee-for-service model.  
5   Not only does the Medicare Advantage program stimulate cost savings for the  
6   Medicare Trust Fund, but it also promotes creation of additional benefits for  
7   Medicare-eligible individuals: “[C]ost savings for the Medicare Trust Fund was  
8   not Congress’s only goal when it created the MA program. Congress structured  
9   the program so that MAOs would compete for enrollees based on how  
10   efficiently they could provide care to Medicare-eligible individuals.” *In re*  
11   *Avandia*, 685 F.3d at 365.

12           27. Achievement of Congress’s goals in enacting Medicare  
13   Advantage is, however, dependent on MAOs being able to achieve cost  
14   savings—like Medicare—through enforcement of the MSP Act by ensuring  
15   primary payers, such as the Defendants in this case, have reimbursed the MAOs  
16   for payments of medical expenses that should have been paid by the insurers  
17   who charged premiums specifically to cover those expenses. *In re Avandia*, 685  
18   F.3d at 363. When MAOs achieve cost savings by recovering conditional  
19   payments from primary payers, they can bid to cover Medicare-eligible

1 individuals at an amount lower than CMS’s benchmark, which then allows  
2 CMS to deposit part of the savings into the Medicare Trust Fund. The MAOs’  
3 which then allows CMS to deposit part of the savings into the Medicare Trust  
4 Fund. The MAOs’ cost savings also allow MAOs to offer “additional benefits  
5 to enrollees not covered by traditional Medicare.” *Id.* at 365. While conditional  
6 payments recovered by MAOs do not go to Medicare directly, the payments by  
7 primary payers do reduce costs, and those savings are passed on to Medicare  
8 through reduced costs or to the beneficiaries through expanded services. *See* 42  
9 U.S.C. § 1395w-23.

10       28. Even though MAOs have parity of recovery rights with Medicare,  
11 insurers such as the Defendants have—for more than two decades—continued  
12 to disregard their reimbursement obligations to MAOs. That failure, which  
13 blocks achievement of Congress’ cost-saving goals, depletes the Medicare  
14 Trust Funds that support Medicare Advantage under Part C—the same funds  
15 supporting traditional Medicare under Parts A and B. 42 U.S.C. § 1395w-23(f).  
16 Consequently, Congress’s mandate that Medicare shall not be the entity  
17 primarily footing the bill is still a long way from being realized. Litigation, such  
18 as this, “ensuring that MAOs can recover from primary payers efficiently with  
19 a private cause of action for double damages does indeed advance the goals of

1 the MA program.” *In re Avandia*, 685 F.3d at 365.

2       29. Achievement of Congress’s goals in enacting Medicare  
3 Advantage is, however, dependent on MAOs being able to achieve cost  
4 savings—like Medicare—through enforcement of the MSP Act by ensuring  
5 primary payers, such as the Defendants in this case, have reimbursed the MAOs  
6 for payments of medical expenses that should have been paid by the insurers  
7 who charged premiums specifically to cover those expenses. *In re Avandia*, 685  
8 F.3d at 363. When MAOs achieve cost savings by recovering conditional  
9 payments from primary payers, they can bid to cover Medicare-eligible  
10 individuals at an amount lower than CMS’s benchmark, which then allows  
11 CMS to deposit part of the savings into the Medicare Trust Fund. The MAOs’  
12 which then allows CMS to deposit part of the savings into the Medicare Trust  
13 Fund. The MAOs’ cost savings also allow MAOs to offer “additional benefits  
14 to enrollees not covered by traditional Medicare.” *Id.* at 365. While conditional  
15 payments recovered by MAOs do not go to Medicare directly, the payments by  
16 primary payers do reduce costs, and those savings are passed on to Medicare  
17 through reduced costs or to the beneficiaries through expanded services. *See* 42  
18 U.S.C. § 1395w-23.

19       30. Even though MAOs have parity of recovery rights with Medicare,

1 insurers such as the Defendants have—for more than two decades—continued  
2 to disregard their reimbursement obligations to MAOs. That failure, which  
3 blocks achievement of Congress’ cost-saving goals, depletes the Medicare  
4 Trust Funds that support Medicare Advantage under Part C—the same funds  
5 supporting traditional Medicare under Parts A and B. 42 U.S.C. § 1395w-23(f).  
6 Consequently, Congress’s mandate that Medicare shall not be the entity  
7 primarily footing the bill is still a long way from being realized. Litigation, such  
8 as this, ensures that MAOs can recover from primary payers efficiently to reach  
9 the goals of the MA program.

10 31. This litigation seeks to reconcile, in an accurate, structured, and  
11 equitable way, claims for reimbursement Defendants have owed for years to  
12 the MAO Assignor. This litigation thus effectively implements Congress’s  
13 original intent in passing the MSP Act.

14 **DEFENDANTS’ DUTIES TO REPORT PRIMARY PAYER**

15 **OBLIGATIONS**

16 32. Defendants are property and casualty insurers in the business of  
17 collecting premiums in exchange for taking on risk that they will have to pay  
18 for personal and property damage resulting from covered events. Collectively,  
19 Defendants offer insurance products in all 50 states and the District of

1 Columbia that have inevitably given rise to an MSP Act obligation to repay  
2 conditional payments made by Plaintiff's MAO Assignor in those states. As a  
3 result, Defendants are tasked with having the proper systems in place to be able  
4 to (a) identify Medicare beneficiaries making claims under Defendants'  
5 policies and (b) properly report them to CMS under section 111 as required by  
6 law.

7 33. Defendants underwrite automobile liability policies that include  
8 first-party and third-party medical coverage. A first-party insurance policy  
9 referred to the policy of the injured person. A third-party insurance policy refers  
10 to the property and bodily injury policy covering the person or entity who was  
11 responsible for the automobile accident. First-party medical coverage includes  
12 Personal-Injury-Protection ("PIP") policies that are usually issued pursuant to  
13 a state no-fault statute or provide Medical Payments Coverage ("MedPay")  
14 found in a first-party policy. The first-party policy can also, and in most  
15 instances does, contain bodily injury coverage. Third-party coverage includes  
16 coverage under a third-party liability policy and coverage under the uninsured  
17 motorist and/or underinsured motorist coverage provisions of a first-party  
18 insurance policy. This coverage pays for medical expenses arising out of an  
19 automobile accident that was the fault of a third party where the third party has

1 no coverage or insufficient coverage to pay the claims of the injured party.

2 34. Defendants have primary payer obligations under the MSP Act to  
3 reimburse MAOs such as Plaintiff's MAO Assignor for medical expenses  
4 arising out of an automobile accident involving a Medicare beneficiary in three  
5 general situations involving both first-party and third-party policies:

6 (1) **Contractual**: When Defendants have a contractual obligation to  
7 pay under a first-party policy such as for PIP or MedPay;

8  
9  
10 (2) **Settlement**: When Defendants settled a bodily injury claim made  
11 against a third party under either a third-party liability policy or  
12 under the uninsured or underinsured motorist coverage provisions  
13 of a first-party policy; and

14  
15 (3) **Hybrid Situations**: Where an accident renders Defendants a  
16 primary payer under both a contractual and a settlement-based  
17 obligation, such as where an auto accident gives rise to claims  
18 under both first-and third-party insurance policies.

19 A. **First Party Policy Claims: First-Party Policy Medical**

1                    **Coverage**

2            35. Defendants are primary payers when they have issued an  
3 insurance policy that provides for first-party medical coverage that pays the  
4 reasonable and necessary medical expenses that an insured (or a passenger)  
5 incurred due to injuries sustained in an accident, regardless of fault. 42 U.S.C.  
6 § 1395y(b)(2)(A). The type of first-party medical coverage varies state by state.  
7 Some states require PIP coverage while other states provide for optional  
8 MedPay coverage. A few states have both PIP and MedPay available.

9            36. Although subject to change among the years at issue (and by no  
10 means exhaustive), the following states currently have no-fault statutes  
11 requiring mandatory PIP coverage:

- 12            • **Florida:** Florida Statute § 627.736 requires a minimum of  
13                    \$10,000.00 in no-fault medical benefits per person;
- 14            • **Hawaii:** Hawaii Revised Statutes § 431:10C-103.5 requires  
15                    a minimum of \$10,000.00 in no-fault medical benefits per  
16                    person;
- 17            • **Kansas:** Kansas Statutes § 40-3103 requires a minimum of  
18                    \$4,500.00 in no-fault medical benefits per person;
- 19            • **Kentucky:** Kentucky Revised Statute § 304.39-020

1 requires a minimum of \$10,000.00 in no-fault medical  
2 benefits per person;

- 3 • **Massachusetts**: Massachusetts General Laws 90 § 34A  
4 requires a minimum of \$8,000.00 in no-fault benefits per  
5 person;

- 6 • **Michigan**: Michigan Compiled Laws § 500.3107 requires  
7 mandatory no-fault coverage at an amount to be selected by  
8 the insured;

- 9 • **Minnesota**: Minnesota Statutes § 65B.44 requires a  
10 minimum of \$40,000.00 in no-fault medical benefits per  
11 person;

- 12 • **New Jersey**: New Jersey § 39:6A-4.3 requires a minimum  
13 of \$15,000.00 in no-fault medical benefits per person;

- 14 • **New York**: 28 Consolidated Laws of New York § 5102  
15 requires a minimum of \$50,000.00 in no-fault benefits per  
16 person;

- 17 • **North Dakota**: North Dakota Century Code § 26.1-41-01  
18 requires a minimum of \$30,000.00 in no-fault benefits per  
19 person;

- 1           •     **Pennsylvania:** 75 Pennsylvania Consolidated Statutes §  
2                     1711 requires a minimum of \$5,000.00 in no-fault medical  
3                     benefits per person; and
- 4           •     **Utah:** Utah Code § 31A-22-307 requires a minimum of  
5                     \$3,000.00 in no-fault benefits per person;

6           37.     In addition, although Oregon is not a no-fault state, it requires  
7     \$15,000.00 per person in PIP medical benefits.

8           38.     In the remaining states (other than Oregon) that are considered “at-  
9     fault” states because they do not have mandatory no-fault coverage, insureds in  
10    some states have the option to purchase PIP coverage or some form of medical  
11    payments coverage (such as in Arkansas, Maryland, South Dakota, Texas,  
12    Virginia, and Washington). In all other states, they may purchase MedPay,  
13    which also pay medical benefits regardless of who was at fault in the accident.  
14    MedPay is mandatory in Maine (\$2,000.00 in medical benefits) and in New  
15    Hampshire if the New Hampshire resident purchases auto insurance, which is  
16    not mandatory (\$1,000.00 in medical benefits). In addition, Pennsylvania  
17    allows individuals to opt out of no-fault insurance in which case the insured  
18    must purchase \$5,000.00 in MedPay coverage.

19          39.     For purposes of this Complaint, “First Party Policy Claims” will

1 refer to those instances in which the MAO Assignor made accident-related  
2 conditional payments on behalf of a Medicare beneficiary that was also an  
3 insured under a first-party policy that provided medical payments regardless of  
4 fault such as PIP or MedPay.

5  
6 **B. Settlement Claims: Third-Party Bodily Injury Coverage**  
7 **Where Defendants Settled A Liability Claim**  
8

9 40. When a Medicare beneficiary is injured in an accident that is the  
10 responsibility of a third party, Defendants may be the insurer of the third party  
11 or may be responsible under the Medicare beneficiary's own policy by virtue  
12 of uninsured or underinsured motorist bodily injury policies ("UM" and "UIM"  
13 policies). Defendants have no obligation to pay benefits under the third-party  
14 policy or the UM/UIM policies unless the third party was "at fault."

15 41. Although the most common types of policies where third-party  
16 liability claims arise are bodily injury liability policies or UM/UIM policies,  
17 third-party liability policies can also include umbrella coverage, which are  
18 policies that may include coverage for medical expenses that the insured is  
19 legally obligated to pay in excess of no-fault or medical-payments coverage,

1   bodily injury policy limits, or UM/UIM coverage.

2           42.   Under any of these policies, if Defendants choose to settle the  
3   Medicare beneficiary's claims, including medical expenses, arising out of the  
4   accident for which the third party was responsible or if a judgment or arbitration  
5   award is entered in the Medicare beneficiary's favor with respect to claims  
6   covered by Defendants' policy, then the Defendants are the responsible primary  
7   payer under the MSP Act.

8           43.   For purposes of this Complaint, "Settlement Claims" refers to  
9   those instances when the MAO Assignor made accident-related conditional  
10   payments on behalf of a Medicare beneficiary who made a claim either against  
11   a third-party liability policy or under the beneficiary's own UM/UIM coverage,  
12   and Defendants' compromised that claim through a settlement, including  
13   settlements arising out of a judgment or arbitration award or otherwise made a  
14   payment that would be the functional equivalent of a settlement or judgment to  
15   cover medical expenses incurred as a result of a specific incident or accident.

16           **C.   Defendants' Obligations Once They Become a Primary Payer**

17           44.   For both "First Party Policy Claims" and "Settlement Claims,"  
18   Defendants are charged with two duties under the MSP Act: (1) to report its  
19   primary payer status under Section 111, and (2) to reimburse Medicare within

1 60 days of receiving a primary payment. The primary plan “must reimburse  
2 Medicare even though it has already reimbursed the beneficiary or other party.”  
3 42 U.S.C. § 1396y(b)(2)(B)(ii); 42 C.F.R. § 411.24(i)(1). If Defendants fail to  
4 reimburse within 60 days, the MSP Act automatically gives rise to a right to  
5 bring an action such as this one. In conjunction with these two duties, it is also  
6 a Primary Payer’s obligation to identify its beneficiaries who are  
7 simultaneously Medicare beneficiaries in order to report and reimburse in  
8 accordance with the MSP Act.

9 45. Section 111 amended the MSP Act to aid Medicare in the  
10 detection of alternative sources of insurance coverage by requiring primary  
11 plans—on their own initiative—to “determine whether a claimant (including  
12 an individual whose claim is unresolved) is entitled to benefits under the  
13 program under this subchapter on any basis”—i.e., including under Medicare  
14 Advantage—and “if the claimant is determined to be so entitled,” to report the  
15 claim to the Secretary. 42 U.S.C. § 1395y(b)(8)(A)-(C).

16 46. The insurer’s Section 111 report must provide “notice about [its]  
17 primary payment responsibility and information about the underlying MSP  
18 situation” to the Medicare payer. 42 C.F.R. § 411.25.

19 47. “The notice must describe the specific situation and the

1 circumstances (including the particular type of insurance coverage as specified  
2 in § 411.20(a)) and, if appropriate, the time period during which the insurer is  
3 primary to Medicare.” *Id.* 42 C.F.R. § 411.25(a)-(c).

4 48. Consequently, to submit a Section 111 report, an auto insurer like  
5 Defendants must obtain certain data from the individuals making first- and  
6 third-party insurance claims. The data that must be obtained and reported  
7 includes:

8 • Medicare Beneficiary Information:

- 9       ▪ Beneficiary name, address, sex, and date of birth  
10       ▪ Beneficiary health insurance claim number (i.e. Medicare  
11       beneficiary identification number or “HIC” number)  
12       ▪ Social security number (if known)

13 • Medicare Claim Information

- 14       ▪ Date of accident, injury, or illness  
15       ▪ Provider of service  
16       ▪ Amount of Medicare payment (if known)  
17       ▪ Date of Service  
18       ▪ Date of Medicare payment (if known)  
19

1           • Insurer, Employer, or Administrator Information:

- 2                   ▪ Policyholder name and address
- 3                   ▪ Name and address of insurer or administrator
- 4                   ▪ Policy identification number or other identifier
- 5                   ▪ Individual case identifiers used by third party payer (if
- 6                   applicable)
- 7                   ▪ Name and phone number of insurer or administrator contact
- 8                   person
- 9                   ▪ Workers' compensation agency claim number (if
- 10                  applicable)
- 11                  ▪ Court case or docket numbers (if applicable)
- 12                  ▪ Beneficiary's attorney's name, address, and phone number
- 13                  (if known and applicable)
- 14                  ▪ Name, address, and phone number of employer
- 15                  ▪ Date and amount of payment made by the insurer (specify
- 16                  whether undisputed payment, settlement of disputed claim,
- 17                  or judgment)
- 18                  ▪ Whether, under the plan of insurance, payment was
- 19                  considered to be a primary or secondary payment

- Payee name and address

*Medicare Program; Medicare Secondary Payment*, 59 Fed. Reg. 4285-01, 4287 (Jan. 31, 1994).

49. More specifically, where Defendants accept coverage under a first-party insurance policy—such as for PIP or MedPay coverage—Defendants have what is called an Ongoing Responsibility for Medicals (“ORM”). ORM is an entity’s “responsibility to pay, on an ongoing basis, for the injured party’s (the Medicare beneficiary’s) ‘medicals’ (medical care) associated with a claim. Typically, ORM only applies to no-fault and workers’ compensation claims.” CMS Section 111.1 NGHP User Guide, Chapter III, Policy Guidance, Version 7.0, Chapter 2: Introduction and Important Terms; *see also* Chapter 6: Responsible Reporting Entities § 6.3.

50. On the other hand, when Defendants settle an accident-related claim based on third-party liability with someone entitled to Medicare benefits, it has what is called a Total Payment Obligation to the Claimant (“TPOC”). The CMS Section 111 NGHP User Guide states that a TPOC “refers to the dollar amount of a settlement, judgment, award, or other payment in addition to or apart from ORM. A TPOC generally reflects a ‘one-time’ or ‘lump-sum’

1 settlement, judgment, award, or other payment intended to resolve or partially  
2 resolve a claim. It is the dollar amount of the total payment obligation to, or on  
3 behalf of the injured party in connection with the settlement, judgment, award,  
4 or other payment.” Chapter III: Policy Guidance, Version 7.0, Chapter 2:  
5 Introduction and Important Terms; *see also* Chapter 6: Responsible Reporting  
6 Entities § 6.4.

7         51. When Defendants have either ORM or TPOC, it is a “Responsible  
8 Reporting Entity” or “RRE” under federal law and are required to submit a  
9 Section 111 report. To submit the report, Defendants must first query the  
10 Medicare eligibility database to determine whether the claimant is a Medicare  
11 beneficiary. CMS’s Benefits Coordination & Recovery Center (“BCRC”)  
12 gives reporting entities two query methods. Because of Defendants’ size, they  
13 must submit requests using a “Query Input File” that will be answered in  
14 fourteen days.

15         52. When uploading a Query Input File with the BCRC to determine  
16 whether a claimant is a Medicare beneficiary, the query record submitted for  
17 each claimant must contain five data elements related to the claimant: (1) Social  
18 Security Number (“SSN”) or Medicare ID; (2) the first 6 characters of the  
19 claimant’s last name; (3) the first initial of the claimant’s first name; (4) the

1 claimant's date of birth; and (5) the claimant's gender. Names must be  
2 submitted exactly as they appear on the individual's Social Security or  
3 Medicare card, including spaces, hyphens, and apostrophes. *Id.* at 26.

4  
5  
6 53. These five pieces of information are *required* to determine a  
7 claimant's entitlement to Medicare benefits and must be gathered by  
8 Defendants for submission to the BCRC.<sup>5</sup> CMS requires all five of the data  
9 elements because "the matching process depends on the quality of the data  
10 submitted. It is difficult to get a match if the input data is incorrect or invalid."<sup>6</sup>

11 54. For the BCRC to find a match in the Medicare database, there must  
12 be an exact match on either: (1) the Medicare ID or the full SSN, and three out  
13 of the four remaining fields; or (2) the partial SSN (last five digits) and all four  
14 remaining fields. Thus, when fewer than three out of the last four criteria match  
15 (i.e., the first initial of the first name, first six characters of the last name, date  
16 of birth, and gender), the RRE will not receive a match even if the submitted  
17 Medicare ID or SSN in fact matches that of a Medicare beneficiary.

---

<sup>5</sup> CMS, MMSEA Section 111 Liability Insurance (including Self-Insurance), No-Fault Insurance, and Workers' Compensation, Query File, January 9, 2023, page 23.

<sup>6</sup> *Id.* at 25.

1           55.     If that claimant is indeed a Medicare beneficiary, Defendants must  
2     provide Section 111 report to CMS “*after* the claim is resolved [by Defendants]  
3     through a settlement, judgment, award, or other payment (regardless of whether  
4     or not there is a determination or admission of liability).” 42 U.S.C. §  
5     1395y(b)(8)(A)(ii) (emphasis added). In other words, once Defendants enter  
6     into a settlement with or make a payment to or on behalf of a Medicare-eligible  
7     beneficiary (and not before), it must file the mandatory Section 111 report.

8           56.     By making a payment on behalf of or entering into a settlement  
9     with a Medicare beneficiary in connection with the Medicare beneficiary’s  
10    accident-related claim, Defendants demonstrate it is the “primary plan” as to  
11    that claim. A primary plan must reimburse Medicare or MAOs for their  
12    conditional payments when it is demonstrated that the primary plan has or had  
13    responsibility to make payment with respect to such item or service, a primary  
14    plan’s responsibility for payment may be shown by a judgment, a payment  
15    conditioned upon the recipient’s compromise, waiver, or release (whether or  
16    not there is a determination or admission of liability) of payment for items or  
17    services included in a claim against the primary plan or the primary plan’s  
18    insured.

19           **DEFENDANTS’ FAILURE TO COMPLY WITH THE MSP ACT**

1           57. For numerous years, and continuing through the present,  
2 Defendants' have failed to comply with its duty to gather the necessary  
3 information from the claimants to enable it to submit all the required data  
4 elements to CMS so that it can identify for Defendants those claimants entitled  
5 to Medicare benefits. This habitual failure frequently results in Defendants  
6 making no Section 111 submission at all. When Defendants fail to make a  
7 Section 111 report, Medicare and MAOs do not have the requisite information  
8 needed to identify a primary payer and to seek reimbursements for conditional  
9 payments.

10           58. Upon information and belief, Defendants track their compliance  
11 with Section 111 through periodic audits conducted to evaluate their success at  
12 collecting and submitting complete data sets for claimants.

13           59. Upon information and belief, the audit reports show Defendants  
14 fail to consistently comply with Section 111. Upon further information and  
15 belief, those reports are shared with Defendants' upper management and  
16 establish Defendants' knowledge that they do not fully comply with their duties  
17 to identify Medicare beneficiaries and, as a result, fail to reimburse claims  
18 conditionally paid by Medicare or MAOs.

19           60. Defendants' failure to obtain the necessary data points to

1 determine a claimant's Medicare eligibility, whether intentional or  
2 unintentional, results in significant under-reporting and, correspondingly, the  
3 inability of Medicare or MAOs to uncover all the instances in which  
4 Defendants owe reimbursement of conditional payments. Defendants are aware  
5 of their obligations under the MSP Act to "determine whether a claimant  
6 (including an individual whose claim is unresolved) is entitled to benefits under  
7 the program under this subchapter on any basis," and has access to the  
8 necessary data to make this determination. In fact, in most instances,  
9 Defendants have the requisite data points in their systems to make this  
10 determination and report their primary payer status pursuant to Section 111 and,  
11 to the degree they do not, are aware of their affirmative statutory duty to obtain  
12 that information.

13         61. Upon information and belief, Defendants fail to properly report  
14 hundreds of reimbursable claims nationwide. Plaintiff compared the claims  
15 data it received from its MAO Assignor to publicly available motor vehicle  
16 accident reports to identify instances where Medicare beneficiaries appear to  
17 have been involved in crashes. Plaintiff then took that pool of beneficiaries and  
18 compared them to Section 111 reports made by Defendants. Upon completion  
19 of that comparison, there are numerous instances where, upon information and

1 belief, it appears Defendants either completely failed to report reimbursable  
2 claims or withdrew a prematurely filed report.

3 **DEFENDANTS' FAILURE TO COORDINATE BENEFITS OR**  
4 **COOPERATE WITH PLAINTIFF'S ATTEMPT TO COORDINATE**  
5 **BENEFITS**  
6

7 62. Even though Defendants, as a primary payer, bear the  
8 responsibility for coordinating benefits and identifying whether Medicare or  
9 any MAO is entitled to reimbursement of conditional payments, Plaintiff  
10 attempted, prior to bringing this lawsuit, to work with Defendants to identify  
11 conditional payments made by Plaintiff's MAO Assignor that Defendants  
12 should have reimbursed. Plaintiff, through its servicer, sent out coordination of  
13 benefits letters via certified mail to Defendants and devoted a tremendous  
14 amount of manpower and resources to try to work with Defendants to resolve  
15 each letter. The letters related to both First Party Policy Claims and Settlement  
16 Claims.

17 63. Plaintiff identified Defendants as the likely primary payer for the  
18 conditional payments reflected in these letters based on reports that Defendants  
19 made under Section 111. Plaintiff accesses the Section 111 reports through a

1 CMS-authorized vendor called MyAbility. MyAbility's data is drawn directly  
2 from data submitted by Defendants to CMS, either itself or through a reporting  
3 vendor Defendants hired. Accordingly, any inaccuracy or lack of specificity in  
4 the data is attributable to Defendants.

5 64. Defendants responded to 540 letters, for an 86% response rate. For  
6 many of those responses, Defendants either refused to provide any information  
7 that would allow the parties to coordinate benefits as the law requires, or  
8 Defendants denied that it had any responsibility based on purported legal  
9 defenses that have no basis in law or fact.

10 65. For the First-Party Policy Claims, Plaintiff attempted to  
11 coordinate benefits for at least 361 instances in which Defendants reported  
12 under Section 111 having made a payment based on the existence of a first-  
13 party insurance policy. Those claims corresponded with payments made by  
14 Plaintiff's MAO Assignor on behalf of Medicare beneficiaries that resided in  
15 33 different states. The top 10 states with the number of claims made in those  
16 states are as follows:

First Party Claims	
State	Count
FL	100

NY	55
NJ	31
UT	31
TX	25
IN	19
PA	11
TN	10
WA	9
NC	12

1

2           66. For the Settlement Claims, Plaintiff attempted to coordinate  
3 benefits for 267 instances in which Defendants acknowledged in a Section 111  
4 filing that it had entered into a settlement with Medicare beneficiary enrolled  
5 with the MAO Assignor under a third-party insurance policy or UM/UIM.  
6 Those claims corresponded with payments made by Plaintiff's MAO Assignor  
7 Plan on behalf of Medicare beneficiaries that resided in 33 different states. The  
8 top 10 states with their total number of beneficiaries are as follows:

### Third Party Claims

State	Count
TX	40
TN	20
WA	20
MO	16
OR	14
CA	12
GA	12
NM	12
CO	11
IN	11

67. Plaintiff devoted significant resources in its attempt to coordinate benefits with Defendants and to avoid litigation. Plaintiff has no choice but to bring this action because its comprehensive and exhaustive efforts to coordinate and work with the Defendants outside of litigation have been unsuccessful. In fact, in their responses to Plaintiff's correspondence, Defendants have habitually stonewalled Plaintiff's effort to coordinate benefits with improper defenses to properly compensable claims. The table below summarizes Defendants' responses to Plaintiff's efforts to coordinate benefits:

Accepting Settlement Offer	2
----------------------------	---

Allege Worker's Compensation Policy	1
Alleging Litigation	929
Beneficiary did not report injuries	4
Confirmed Settlement	156
Contact Attorney Only	899
Contesting Billed Amount	4
Contesting Double Damages	1
Contesting MSP Assignment & Failed To Provide Assignment of Benefits	2
Contesting Relatedness	7
Different Date of Accident	1
Disclosed Beneficiary Attorney	141
Disclosed First Party Insurer	5
Disclosed Third Party Insurer	1
Duplicate Claims	1
E2MSP Reply	2
Exhaustion	21

Failed to attach itemized bill	67
Failed to provide proper claim-policy number	12
Failed to send to proper address	2
First Party Insurer Claim Open	2
First Party Insurer made payment	3
Ins Company Allege Not Medicare Beneficiary	1
Member Not Covered	32
Notice of Pending Settlement	1
Privileged Communication	1
Provided CMS Information	3
Received Full Payment	4
Received Partial Payment	10
Received Response to MSP Demand	72
Requested Additional Extension Past 30 Days	1
Requesting Extension	1
Settlement Negotiation	2
Statute of Limitations	18

Stop Payment Notice	7
Subro Closing Notification	12
Subrogation (Paid Lien)	8
Third Party Insurer Claim Open	9
Third Party Insurer Did Not Accept Liability	23
Unable to Access Portal	1
Unable to Locate Claim-Insured	216

1

2

3           68. Defendants also refused to share any data with Plaintiff for the  
4 purpose of identifying situations where Defendants were a primary payer but  
5 did not submit a Section 111 report—a process that numerous other carriers  
6 have agreed to explore outside of litigation. Defendants' actions in refusing to  
7 coordinate benefits are purposeful and designed to continue to conceal details  
8 of its primary payer responsibility when it has failed to submit a Section 111  
9 report.

10           69. Through this action, Plaintiff seeks to identify all instances in  
11 which Defendants had a primary payer responsibility to reimburse accident-  
12 related conditional payments made by Plaintiff's MAO Assignor. The most

1 efficient and fair way to quantify those damages is through a process that  
 2 resembles what several other carriers are already doing voluntarily. To identify  
 3 undetected claims for primary payers *other than* Defendants, Plaintiff has  
 4 engaged in data sharing exercises with those other primary payers, who are also  
 5 property and casualty insurers, in which the parties match data to identify all  
 6 the instances in which a MAO made payments that overlap with first- or third-  
 7 party claim made to the insurer by a Medicare beneficiary enrolled with the  
 8 MAO. This process uses matching techniques that compensate for missing data  
 9 and data imperfections and is consistent with Congress’s intention in enacting  
 10 the MSP Act to ensure that Medicare and, ultimately, MAOs (Part C plans) are  
 11 repaid in *all instances* where an insurer is primary.<sup>7</sup>

---

<sup>7</sup> See, e.g., (1) **Allstate Insurance Company** (*MSPA Claims I, LLC v. Allstate Ins. Co.*, Case No. 1:17-cv-01340, D.E. 169 (N.D. Ill. Mar. 8, 2022)) (no-fault settlement exploration through data sharing); *MSP Recovery Claims I, LLC v. Allstate Ins. Co.*, Case No. 20-cv-24140 at Dkt. No. 70 (S.D. Fla. 2020)) (bodily injury settlement exploration through data sharing), (2) **Auto-Owners Insurance Company** (*MSP Recovery Claims, Series LLC v. Auto-Owners Ins. Co.*, Case No. 17-cv-23841 at Dkt. No. 143 (S.D. Fla. 2022)) (settlement exploration through data sharing and noting in the joint report requesting dismissal that “[t]he parties believe that the best opportunity to finally resolve their disputes will be to continue engaging in a data matching process agreed to by the parties” and “this exercise is a reconciliation that be handled by the parties outside of litigation”); (3) **National General Insurance Company** (*MSP Recovery Claims, Series LLC, et al. v. Integon Nat. Ins. Co., et al.*, Case No. 20-cv-24051, D.E. 147 (S.D. Fla. 2022)) (settlement exploration through data sharing), (4) **Sentry Insurance Company** (*MSP Recovery Claims, Series LLC v. Dairyland Ins. Co.*, Case No. 17-cv-23983 at Dkt. No. 91 (S.D. Fla. 2020)) (no-fault and bodily injury settlement exploration through data sharing); (5) **Grange Insurance Company** (*MSP Recovery Claims, Series LLC v. Grange Ins. Co.*, Case No. 19-cv-219 at Dkt. No. 36 (N.D. Ohio 2019)) (noting in joint report that Grange agreed to “engage in a defined claims data

## STANDING ALLEGATIONS

### A. Assignment Allegations

70. Plaintiff has the legal right to pursue its MSP Act claim pursuant to a valid assignment agreement.<sup>8</sup>

71. On December 23, 2021, Plaintiff's MAO Assignor entered into a Claims Assignment Agreement with Series 15-09-321, whereby the MAO Assignor irrevocably assigned all rights to recover payments made on behalf of its members/enrollees (the "2021 Assignment Agreement"). The 2021 Assignment Agreement expressly provides, in pertinent part:

Assignor irrevocably assigns, transfers, conveys, sets over and delivers to Assignee any and all of Assignor's right, title,

matching process” to explore settlement, which resulted in a global settlement); (6) **Esurance Insurance Services, Inc** (*MSP Recovery Claims Series, LLC v. Esurance Property and Casualty Co.*, Case No. 20-cv-23590 at Dkt. No. 50 (S.D. Fla. 2020)) (no-fault and bodily injury settlement exploration through data sharing); (7) **Amica Mutual Insurance Company** (*MSP Recovery Claims, Series LLC v. Amica Mut. Ins. Co.*, Case No. 20-cv-24050, D.E. 42 (S.D. Fla. May 6, 2022)) (settlement exploration through data sharing); (8) **Horace Mann Insurance Company** (*MSP Recovery Claims, Series LLC v. Horace Mann Ins. Co.*, Case No. 20-cv-24419, Dkt. No. 40 (S.D. Fla. July 9, 2021)) (global settlement reached based on data sharing); (9) **1199 SEIU National Benefit and Pension Funds** (*MSP Recovery, LLC v. 1199 SEIU Nat’l Benefit and Pension Funds*, Case No. 20-cv-1480) (global settlement reached following data sharing).

<sup>8</sup> A separate data service agreement with Plaintiff's MAO Assignor contains a provision requiring that the identity of the Assignor remain confidential. Accordingly, Plaintiff has omitted the name of its assignor from this Complaint. Accordingly, Plaintiff has omitted the name of its assignor from this Complaint. Should the Court deem it necessary, Plaintiff will disclose its MAO Assignor's identity, but would request that the identity be disclosed under seal.

1 ownership, and interest in Medicare Advantage Parts A, B, and C  
2 payments owed by Responsible Parties pursuant to the MSPA, by  
3 and through the following causes of action: (1) actions stemming  
4 from the MSPA; (2) breach of contract; (3) pure bills of discovery  
5 or equivalent; (4) depositions or discovery before action as set  
6 forth by Federal Rule of Civil Procedure 27; (5) subrogation; (6)  
7 declaratory action; (7) unjust enrichment, whether known or  
8 unknown, or arising in the future (the “Claims”).  
9

10 2021 Assignment Agreement at 1.1.1.

11 72. Consideration was exchanged by the parties in executing the 2021  
12 Assignment and the data service agreement.

13 73. The “Claims” expressly exclude claims where the MAO Assignor  
14 already recovered on the claim or is currently pursuing the claim.

15 74. The MAO Assignor transferred data files to Plaintiff indicating  
16 those claims where it already had recovered money and those claims where the  
17 MAO Assignor is still pursuing recoveries. Plaintiff reviewed that list prior to  
18 filing this case and conferred with the Assignor, in an abundance of caution, to  
19 confirm that the assignor (1) never recovered money for the examples set forth

below and (2) is not pursuing recoveries for the examples below. Accordingly, these examples remain unpursued and unreimbursed, and not excluded, and Plaintiff have the legal right to pursue these claims.

75. The claims set forth in this Complaint are not subject to any carveout, exclusion, or any other limitation in law or equity that would impair Plaintiff's right to bring the claim asserted in this case.

76. This Complaint seeks recovery only for claims Plaintiff's assignor has assigned to Plaintiff through its Designated Series (Series 15-09-321). All claims at issue in this Complaint, and all claims data currently in Plaintiff's possession, were assigned to Plaintiff through the 2021 Assignment Agreement. Indeed, Plaintiff has possession of the electronic claims data for each example of non-reimbursement identified in this Complaint solely because Plaintiff's Assignor provided that data to Plaintiff pursuant to the 2021 Assignment Agreement.

**Examples Of Unreimbursed First Party Policy Party Claims**

**And Settlement Claims**

1           77. Defendants, by failing to comply with the MSP Act and reimburse  
2 Plaintiff's MAO Assignor for conditional payments, has caused monetary  
3 injury to Plaintiff's MAO Assignor sufficient to establish a concrete injury in  
4 fact under Article III. Despite very little cooperation from Defendants, Plaintiff  
5 has identified from data transferred to it by the MAO Assignor and further  
6 investigation several examples of Defendants' failure to comply the MSP Act.

7           78. Adhering to how CMS identifies instances of non-reimbursed  
8 conditional payments, Plaintiff analyzed the MAO Assignor's enrollment and  
9 claims data to identify situations where: (1) the MAO Assignor had a Medicare  
10 beneficiary enrollee injured in an accident, (2) Defendants filed a Section 111  
11 report regarding that enrollee, (3) the MAO Assignor made accident-related  
12 payments on behalf of that enrollee, and (4) Defendants failed to reimburse the  
13 MAO Assignor's conditional payments. Plaintiff confirmed that Defendants  
14 either acknowledged that the enrollee was covered by Defendants or that  
15 Defendants had entered into a settlement with the enrollee arising out of the  
16 accident.

17           79. Specifically, CMS uses what is reported through Section 111 to  
18 identify whether any claims that Medicare either receives or pays are related to  
19 an automobile accident. <https://www.cms.gov/files/document/mmsea-111->

1 [august-7-2023-nghp-user-guide-version-73-chapter-iv-technical-](#)  
2 [information.pdf](#) at Section 6.2.5 (last visited October 1, 2023). CMS requires  
3 the Section 111 report to contain certain codes (called International  
4 Classification of Diseases, Ninth/Tenth Revision, Clinical Modification (ICD-  
5 9/ICD-10) that describe the “alleged illness, injury, or incident claims and/or  
6 released by the settlement, judgment, or award, or for which ORM [under a  
7 first-party coverage] is assumed.” *Id.* “The ICD-9/ICD-10 codes are used by  
8 Medicare to identify claims Medicare may receive, related to the incident, for  
9 Medicare claims payment and recovery purposes.” *Id.*

10 80. CMS provides to reporting entities, such as Defendants, a list of  
11 valid ICD codes, and that list can be accessed here:  
12 [https://www.cms.gov/medicare/coordination-benefits-recovery-overview/icd-](https://www.cms.gov/medicare/coordination-benefits-recovery-overview/icd-code-lists)  
13 [code-lists](https://www.cms.gov/medicare/coordination-benefits-recovery-overview/icd-code-lists) (last visited October 1, 2023). The list is segregated into those codes  
14 that are “valid” versus those that are “excluded.” “Certain codes are not valid  
15 for No-Fault insurance types . . . because they are not related to the accident,  
16 and may result in inappropriately denied claims.” *Id.* For all the examples of  
17 un-reimbursed secondary payments set forth in, each of the accident-related  
18 payments that the MAO Assignor made on behalf of the Medicare beneficiary  
19 fall within the list of “valid” codes that CMS itself looks at when initiating

1 recovery. In other words, CMS, as an initial matter, would consider as accident-  
2 related all the payments set forth below that the MAO Assignor made related  
3 to the accident.

4 81. Moreover, with respect to the injuries that Defendants reported  
5 under Section 111, all the injuries contained within Defendants' Section 111  
6 reports reflect injuries that are identical, or very similar, to the injuries that  
7 resulted in health care providers providing medical items and services to the  
8 MAO enrollee and thereafter billing and collecting from the MAO Assignor.  
9 CMS's manual states that it would hold Defendants responsible for reimbursing  
10 Medicare for any payments that Medicare made for same or similar injuries.<sup>9</sup>  
11 In fact, CMS issued a training manual for reporting entities such as Defendants,  
12 stating that "ICD Diagnosis codes are also important for claims recovery"  
13 because "if [Defendants] [have] assumed ORM for a beneficiary's broken  
14 collar bone injury due to a no-fault policy claim, the Commercial Repayment  
15 Center (CRC) will use the submitted ICD diagnosis codes to search Medicare  
16 records for claims paid by Medicare that are related to the case."<sup>10</sup>

---

<sup>9</sup> <https://www.cms.gov/files/document/mmsea-111-august-7-2023-nghp-user-guide-version-73-chapter-iv-technical-information.pdf> at Section 6.2.5 (last visited October 1, 2023).

<sup>10</sup> <https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/NGHP-Training->

1           82. Further, according to the CMS manual: “If Medicare has made  
2 primary or conditional payment on claims related to the incident that should  
3 have been paid by other insurance, the CRC will pursue recovery from the  
4 insurer for the Medicare benefits paid.” *Id.* Medicare likewise would hold  
5 Defendants accountable for reimbursing any Medicare payments for injuries  
6 that resulted in the settlement of a third-party liability claim. For example, if  
7 Defendants reported that it settled a claim involving injuries such as a sprain of  
8 the neck and a sprain of the ankle, Medicare “will use this information to search  
9 Medicare claims history,” “identify any claims paid primary . . . that relate to  
10 the neck and ankle sprains,” and pursue recovery. *Id.* “An exact match on the  
11 submitted ICD-9 diagnosis codes . . . is not required.” *Id.* As noted above and  
12 reflected below, all the injuries that Plaintiff identified are either identical, or  
13 very similar, to what Defendants reported in their Section 111 reports.

14           83. Additionally, for each of the examples, Plaintiff confirmed that  
15 Defendants either acknowledged that the enrollee was covered by a Defendants  
16 policy or that Defendants had entered into a settlement with the enrollee arising  
17 out of the accident. Defendants also knew or should have known that its insured

---

[Material/Downloads/ICD-Diagnosis-Code-Requirements-Part-I.pdf](#) at p. 7 (last visited August 8, 2023).

1 was a Medicare beneficiary and therefore had constructive knowledge of its  
2 duty to reimburse the MAO Assignor.

3 84. The following examples of First Party Policy Claims and  
4 Settlement Claims illustrate Defendants' failure to fulfill their statutory duties  
5 to reimburse the MAO Assignor for conditional payments when it knew that  
6 the individuals making Defendants' insurance claims were also entitled to  
7 Medicare benefits. The representative Medicare beneficiaries listed below  
8 (identified by initials for confidentiality reasons) are illustrative examples of  
9 the many claims Defendants have failed to reimburse.

10 85. The scope of Plaintiff's claims is not limited to the represented  
11 beneficiaries listed below. Plaintiff's claims seek reimbursement and other  
12 relief for the thousands of conditional payments that to date remain  
13 unreimbursed by Defendants.

14 86. The examples below detail the facts that demonstrate (1) the MAO  
15 Assignor made conditional payments for treatment to address injuries caused  
16 by an auto accident; (2) a Defendant was a primary plan with respect to that  
17 accident; (3) a Defendant had a demonstrated responsibility to pay or reimburse  
18 the MAO Assignor's conditional payments; and (4) a Defendant did not  
19 reimburse the MAO Assignor for its conditional payments, causing the MAO

1 Assignor to sustain damages. For each claim below, the MAO Assignor  
2 executed an assignment to Plaintiff allowing Plaintiff to pursue the specific  
3 recovery of damages; the MAO Assignor did not retain any reimbursement  
4 rights; and Plaintiff satisfied all conditions precedent (to the extent any exist)  
5 to bring these claims.

6 **First Party Policy Claims Examples**

7 85. L.G. was injured in an automobile accident on January 26, 2017.  
8 At that time, L.G. was enrolled in Plaintiff's MAO Assignor's MA Plan.

- 9 a. At the time of the accident, L.G. was insured by a  
10 Mid-Century Insurance Company no-fault policy  
11 having policy number 0191628724.
- 12 b. On the date of the accident, L.G. sustained lower  
13 back and chest injuries, causing L.G. to suffer  
14 Dorsalgia (lower back pain) and chest pain.
- 15 c. Two days later, L.G. visited the emergency room at  
16 the Hartford Hospital in Hartford, Connecticut and  
17 received treatment for the accident injuries from  
18 physician assistant Nicholas Wayne Chasse and  
19 Radiology Dr. Angabeen S. Khan.

1           d.     The auto accident caused the injuries set forth above.

2           e.     Treatment of L.G.'s lower back and chest injuries  
3                 was reasonable and necessary.

4           f.     L.G.'s medical providers billed the MAO Assignor  
5                 \$1,679.44 for the above accident-related treatment  
6                 and the MAO Assignor paid \$466.18 for treatment of  
7                 L.G.'s accident-related injuries. The diagnosis codes  
8                 contained within the medical bills from the medical  
9                 providers, relating to the accident-related treatments,  
10                are on the list of valid CMS codes. Moreover, the  
11                MAO Assignor paid for treatment of accident injuries  
12                that are either the same as, or similar to, the injuries  
13                that Mid-Century Insurance Company reported  
14                pursuant to Section 111.

15          g.     Mid-Century Insurance Company's Section 111  
16                 report for L.G. admits the following details about the  
17                 claims:

18          i.     L.G. was insured by Mid-Century Insurance  
19                 Company.

1                   ii.       The accident caused L.G. to suffer Dorsalgia  
2                               (lower back pain) and chest pain.

3                   iii.       L.G.'s Medicare coverage was secondary, and  
4                               L.G.'s Mid-Century Insurance Company's  
5                               No-Fault Auto Insurance was primary.

6                   iv.       The Plan name was Farmers Insurance.

7           86.    J.P. was injured on April 29, 2019. At that time, J.P. was  
8   enrolled in Plaintiff's MAO Assignor's MA Plan.

9                   a.   At the time of the accident Foremost  
10                       Insurance Company Grand Rapids,  
11                       Michigan insured Business Atkinson Real  
12                       Estate Investment with policy number  
13                       5000859974 that included a no-fault  
14                       coverage policy.

15           b.   On the date of the accident, J.P. sustained hip and  
16                       knee injuries, causing J.P. to suffer pain in right hip  
17                       and bilateral primary osteoarthritis of the knee.

18           c.   The same day of the accident, J.P. visited the  
19                       Watertown Regional Medical Center, Wisconsin and

1 received treatment for the accident injuries from  
2 Radiology Dr. Brian T Lipman and nurse practitioner  
3 Dana M. Stinnet.

4 d. The accident caused the injuries set forth above.

5 e. Treatment of J.P.'s hip and knee injuries was  
6 reasonable and necessary.

7 f. J.P.'s medical providers billed the MAO Assignor  
8 \$451.00 for the above accident-related treatment and  
9 the MAO Assignor paid \$115.10 for treatment of  
10 J.P.'s accident-related injuries. The diagnosis codes  
11 contained within the medical bills from the medical  
12 providers, relating to the accident-related treatments,  
13 are on the list of valid CMS codes. Moreover, the  
14 MAO Assignor paid for treatment of accident injuries  
15 that are either the same as, or similar to, the injuries  
16 that Foremost Insurance Company Grand Rapids,  
17 Michigan reported pursuant to Section 111.

18 g. Foremost Insurance Company Grand Rapids,  
19 Michigan's Section 111 report for J.P. admits the

1 following details about the claims:

2 v. The accident caused J.P. to suffer pain in  
3 unspecified knee.

4 vi. J.P.'s Medicare coverage was secondary, and  
5 Foremost Insurance Company Grand Rapids,  
6 Michigan's No-Fault Insurance was primary.

7 vii. The Plan name was National Document  
8 Center.

9 viii. The insured is Business Atkinson Real Estate  
10 Investment.

11 ix. The insured policy number is 5000859974.

12 87. J.P.2. was injured in an automobile accident on July 04, 2018. At that  
13 time, J.P.2. was enrolled in Plaintiff's MAO Assignor's MA Plan.

14 a. On the day of the accident, J.P.2. was waiting for  
15 another vehicle in front of her while in the drive-  
16 through of a Walmart Pharmacy when she was hit  
17 from behind. J.P.2. informed the officer that took  
18 down her statement for the Traffic Collision Report  
19 that "her chest was hurt[] from hitting the steering

1 wheel.”

2 b. At the time of the accident, J.P.2. was insured by a  
3 Farmers Insurance Company, Inc., under a no-  
4 fault/MedPay policy with the policy number  
5 0186658318.

6 c. On the date of the accident, J.P.2. sustained cervical  
7 and lung injuries, causing J.P.2. to suffer Cervicalgia  
8 (neck pain) and other disorders of lung.

9 d. The same day as the accident, J.P.2. visited Norman  
10 Regional Moore, Oklahoma and received treatment  
11 for the accident injuries from physician Gautam  
12 Dehadrai, associate of NRHS Radiology Associates.

13 e. The auto accident caused the injuries set forth above.

14 f. Treatment of J.P.2.’s cervical and lung injuries was  
15 reasonable and necessary.

16 g. J.P.2.’s medical providers billed the MAO Assignor  
17 \$77.00 for the above accident-related treatment and  
18 the MAO Assignor paid \$22.23 for treatment of  
19 J.P.2.'s accident-related injuries. The diagnosis codes

1 contained within the medical bills from the medical  
2 providers, relating to the accident-related treatments,  
3 are on the list of valid CMS codes. Moreover, the  
4 MAO Assignor paid for treatment of accident injuries  
5 that are either the same as, or similar to, the injuries  
6 that Farmers Insurance Company, Inc. reported  
7 pursuant to Section 111.

8 h. Farmers Insurance Company, Inc's Section 111  
9 report for J.P.2. admits the following details about the  
10 claims:

11 i. J.P.2. was insured by Farmers Insurance  
12 Company, Inc.

13 ii. The accident caused J.P.2. to suffer sprain of  
14 ligaments of cervical spine.

15 iii. J.P.2.'s Medicare coverage was secondary,  
16 and J.P.2.'s Farmers Insurance Company,  
17 Inc.'s No-Fault Auto Insurance was primary.

18 iv. The Plan name was National Document  
19 Center.

1           88.    The plan or contract number was 0186658318.K.K. was injured in  
2   an automobile accident on March 21, 2019. At that time, K.K. was enrolled in  
3   Plaintiff's MAO Assignor's MA Plan.

4           a.    At the time of the accident, K.K. was insured by a  
5               Farmers Insurance Company, Inc., liability policy  
6               having policy number 0192153210.

7           b.    The incident caused K.K to suffer injuries to: his  
8               right wrist, hand and finger(s); chest pain, contusion  
9               of unspecified front wall of thorax; and localized  
10              edema.

11          c.    The same day of the accident, K.K. received  
12               treatment for the accident injuries from advanced  
13               nurse practitioner Carolyn Marley, Dr. Mark  
14               Newport, Dr. Jordan Anthony Chance, and Dr. Julie  
15               Alford.

16          d.    The auto accident caused the injuries set forth above.

17          e.    Treatment of K.K.'s right wrist, hand and finger(s);  
18               chest pain, contusion of unspecified front wall of  
19               thorax, and localized edema injuries was reasonable

1 and necessary.

2 f. K.K.'s medical providers billed the MAO Assignor  
3 \$316.00 for the above accident-related treatment and  
4 the MAO Assignor paid \$84.72 for treatment of  
5 K.K.'s accident-related injuries. The diagnosis codes  
6 contained within the medical bills from the medical  
7 providers, relating to the accident-related treatments,  
8 are on the list of valid CMS codes. Moreover, the  
9 MAO Assignor paid for treatment of accident injuries  
10 that are either the same as, or similar to, the injuries  
11 that Farmers Insurance Company, Inc. reported  
12 pursuant to Section 111.

13 g. Farmers Insurance Company, Inc.'s Section 111  
14 report for K.K. admits the following details about the  
15 claims:

16 i. K.K. was insured by Farmers Insurance  
17 Company, Inc.

18 ii. The accident cause K.K. to suffer injuries of  
19 unspecified wrist, hand and finger(s) an injury of

1 thorax.

2 iii. K.K.'s Medicare coverage was secondary, and  
3 K.K.'s Farmers Insurance Company, Inc's liability  
4 insurance was primary.

5 iv. The Plan name was Farmers Insurance  
6 Company.

7 **Settlement Claims Examples**

8 87. When Defendants enter into a settlement agreement with an  
9 injured party who is enrolled in a Medicare plan, Defendants become primary  
10 payers that are responsible for reimbursement of medical services rendered to  
11 the injured party. After executing settlement agreements in each instance  
12 identified below, Defendants failed to provide actual notice of its primary payer  
13 status to the Medicare participants who paid for the beneficiaries' medical  
14 expenses and failed to reimburse the MAO Assignor for its conditional  
15 payments.

16 88. J.F. was injured in an automobile accident on September 14, 2018,  
17 near **Pahrump, Nevada**. At that time, J.F. was enrolled in Plaintiff's MAO  
18 Assignor's MA Plan.

19 a. The Farmers' insureds responsible for the September

1 14, 2018. incident were C.B. and L.B. Farmers  
2 Insurance Exchange, in response to Series 15-09-  
3 321's coordination of benefits letter, disclosed that  
4 C.B. and L.B. were insured by it under Policy  
5 number: 0317539143.<sup>11</sup>

6 b. The incident caused J.F. to suffer an injury to the  
7 shoulder and upper arm; more specifically, a  
8 puncture wound without foreign body of the right  
9 forearm, and an open bite of J.F.'s right shoulder.

10 c. J.F. was transported on September 14, 2018, by the  
11 Pahrump Valley Fire Rescue and received treatment,  
12 at the Desert View Hospital ("DVH") in **Pahrump,**  
13 **Nevada** on that day and the following.

14 d. Follow-up outpatient treatment related to these  
15 injuries continued on September 17, 2018, October 9,  
16 2018, October 24, 2018, and November 5, 2018.

17 e. The incident caused the injuries set forth above.

18 f. Treatment of J.F.'s right forearm and shoulder was

---

<sup>11</sup> Farmers Insurance Exchange reported to CMS with the Claim Number: 3011579591-1-2, instead of with the Policy Number it later disclosed.

1 reasonable and necessary.

2 g. J.F.'s medical providers billed the MAO Assignor  
3 \$14,460.79 for the above accident-related treatment  
4 and the MAO Assignor paid \$2490.30 for treatment  
5 of J.F.'s incident-related injuries. The diagnosis  
6 codes contained within the medical bills from the  
7 medical providers, relating to the incident-related  
8 treatments, are on the list of valid CMS codes.  
9 Moreover, the MAO Assignor paid for treatment of  
10 incident injuries that are either the same as, or similar  
11 to, the injuries that Farmers Insurance Exchange  
12 reported pursuant to Section 111.

13 h. J.F. filed a third-party claim against C.B. and L.B.'s  
14 bodily injury policy, seeking as damages  
15 reimbursement of medical expenses incurred by the  
16 MAO Assignor for the incident-related injuries set  
17 forth above.

18 i. Farmers Insurance Exchange entered into a  
19 settlement with J.F. on 2019, with respect to this

1                   third-party bodily injury claim, arising from the  
2                   incident on September 14, 2018.

3                   j.     Farmers Insurance Exchange paid J.F. \$215,000 in  
4                   exchange for a release of all claims arising out of the  
5                   September 14, 2018 incident, including the claim for  
6                   reimbursement of medical expenses resulting from  
7                   the incident.

8                   k.     Farmers Insurance Exchange's Section 111 report for  
9                   J.F. admits the following details about the claims:

10                  i.     The settling party was Farmers Insurance  
11                  Exchange's insured.

12                  ii.    The incident caused J.F. to suffer an  
13                  unspecified injury to the shoulder and upper  
14                  arm (unspecified arm); and unspecified injury  
15                  of unspecified forearm. Further, the settlement  
16                  agreement released J.F.'s claim for medical  
17                  expenses relating to these injuries.

18                  iii.   J.F.'s Medicare coverage was secondary, and  
19                  the liability insurance was primary.

1                   iv.       Despite the settling party being insured by  
2                               Farmers Insurance Exchange the applicable  
3                               Plan name reported was Farmers Insurance  
4                               Company.

5           89.   L.J. was injured in a traffic accident, on August 1, 2019, at Steve  
6   Reynolds Blvd and Redgate Road, **Gwinnett County, Georgia**. At that time,  
7   L.J. was enrolled in Plaintiff's MAO Assignor's MA Plan

8                   1.       The Farmers' insured responsible for the August 1,  
9                               2019, traffic accident was N.D. Farmer's entity Mid-  
10                              Century Insurance Company, in response to Series  
11                              15-09-321's coordination of benefits letter, disclosed  
12                              that N.D. was insured by it under Policy number:  
13                              0187388324.<sup>12</sup>

14                  m.       The traffic accident collision caused L.J. to suffer  
15                              injuries including, but not limited to: unspecified  
16                              injury of neck; cervicalgia (neck pain); unspecified  
17                              injury of shoulder and upper arm (unspecified arm);  
18                              unspecified injury of unspecified forearm;

---

<sup>12</sup> Mid-Century Insurance Company reported to CMS this liability primary payer responsibility under Contract/Plan Number: 030.

1 unspecified injury of unspecified hip; pain in right  
2 hip; low back pain; unspecified injury of unspecified  
3 lower leg; and unspecified injury of unspecified foot.

4 n. L.J.'s doctor noted that L.J.'s outpatient office visit,  
5 examination, and treatment on August 5, 2019, was  
6 due to a traffic accident collision with a nonmotor  
7 vehicle, while L.J. was driving a car.

8 o. The auto accident caused the injuries set forth above.

9 p. Treatment of L.J.'s neck, lower back, and hip injuries  
10 were reasonable and necessary.

11 q. L.J.'s medical provider billed the MAO Assignor  
12 \$180.00 for the above accident-related treatment and  
13 the MAO Assignor paid \$86.59 for treatment of  
14 L.W.'s accident-related injuries. The diagnosis codes  
15 contained within the medical bill from the medical  
16 provider, relating to the accident-related treatments,  
17 are on the list of valid CMS codes. Moreover, the  
18 MAO Assignor paid for treatment of accident injuries  
19 that are either the same as, or similar to, the injuries

1                   that Farmers reported pursuant to Section 111.

2                   r.     L.J. filed a third-party claim against N.D.'s bodily  
3                   injury policy, seeking as damages reimbursement of  
4                   medical expenses incurred by the MAO Assignor for  
5                   the accident-related injuries set forth above.

6                   s.     Mid-Century Insurance Company settled the bodily  
7                   injury claim on December 8, 2021, paying L.J..  
8                   \$16,800.00 in exchange for a release of claims  
9                   against N.D., arising out of the August 1, 2019,  
10                  accident.

11                  t.     Mid-Century Insurance Company's Section 111  
12                  report for L.J. admits the following details about the  
13                  claims:

14                  i.     The settling party was Mid-Century Insurance  
15                  Company's insured.

16                  ii.    The auto accident caused L.J. to suffer  
17                  unspecified injury of neck; unspecified injury  
18                  of unspecified hip; low back pain; unspecified  
19                  injury of shoulder and upper arm (unspecified

1 arm); unspecified injury of unspecified  
2 forearm; unspecified injury of unspecified  
3 lower leg; and unspecified injury of  
4 unspecified foot. Further, the settlement  
5 agreement released L.J.'s claim for medical  
6 expenses relating to these injuries.

7 iii. L.J.'s Medicare coverage was secondary, and  
8 the liability insurance was primary.

9 iv. The Plan name was Farmers Insurance  
10 Company.

11 90. M.A. was injured in an automobile accident on January 11, 2017.

12 At that time, M.A. was enrolled in Plaintiff's MAO Assignor's MA Plan.

13 a. The Farmers' insured responsible for the January 11,  
14 2017 automobile accident was L.B. Farmer's entity  
15 21st Century Centennial Insurance Co., in response  
16 to Series 15-09-321's coordination of benefits letter,  
17 disclosed that L.B. was insured by it under Policy

1 number: 0020362824.<sup>13</sup>

2 b. The auto accident caused M.A. to suffer injuries  
3 including, but not limited to: sprain of joints and  
4 ligaments of other parts of neck, pain in right knee,  
5 and low back pain.

6 c. M.A. received treatment at Newark Beth Israel  
7 Medical Center (“NBIMC”) in **Newark, New**  
8 **Jersey**, for the knee and lumbar injuries, during an  
9 outpatient office visit, on January 20, 2017.

10 d. Treatments to M.A. in the outpatient visit included  
11 M.A.’s evaluation and management by an internal  
12 medicine doctor, as well as three x-ray images of  
13 M.A.’s right knee and four x-ray images of M.A.’s  
14 lumbosacral spine, taken at the NBIMC Department  
15 of Radiology and informed by a Radiology doctor.

16 e. The auto accident caused the injuries set forth above.

17 f. Treatment of M.A.’s right knee and lumbosacral

---

<sup>13</sup> 21st Century Centennial Insurance Co. reported to CMS with this same Contract/Plan Number: 0020362824.

1 spine injuries was reasonable and necessary.

2 g. M.A.'s medical providers billed the MAO Assignor  
3 \$1,864.00 for the above accident-related treatment  
4 and the MAO Assignor paid \$240.13 for treatment of  
5 M.A.'s accident-related injuries. The diagnosis codes  
6 contained within the medical bills from the medical  
7 providers, relating to the accident-related treatments,  
8 are on the list of valid CMS codes. Moreover, the  
9 MAO Assignor paid for treatment of accident injuries  
10 that are either the same as, or similar to, the injuries  
11 that 21st Century Centennial Insurance Co. reported  
12 pursuant to Section 111.

13 h. M.A. filed a third-party claim against the bodily  
14 injury policy of 21st Century Centennial Insurance  
15 Co. insured, seeking as damages reimbursement of  
16 medical expenses incurred by the MAO Assignor for  
17 the accident-related injuries set forth above.

18 i. 21st Century Centennial Insurance Co. settled the  
19 bodily injury claim on an undisclosed date, in

1 exchange for a release of claims against Farmers  
2 insured, arising out of the January 20, 2017 accident.

3 j. 21st Century Centennial Insurance Co.'s Section 111  
4 report for M.A. admits the following details about the  
5 claims:

6 i. The settling party was Farmers' insured.

7 ii. The auto accident caused M.A. to suffer sprain  
8 of joints and ligaments of other parts of neck.  
9 Further, the settlement agreement released  
10 M.A.'s claim for medical expenses relating to  
11 these injuries.

12 iii. M.A.'s Medicare coverage was secondary, and  
13 the liability insurance was primary.

14 iv. The Plan name was National Document Center  
15 with a Farmers' address.

16 91. P.W. was injured in an automobile accident on March 17, 2017,  
17 near Everett, WA. At that time, P.W. was enrolled in Plaintiff's MAO  
18 Assignor's MA Plan.

19 a. The Farmers Insurance Company of Washington

1 insured responsible for the March 17, 2017, accident  
2 was G.C. Farmers Insurance Company of  
3 Washington, in response to Series 15-09-321's  
4 coordination of benefits letter, disclosed that G.C.  
5 was insured by Farmers Insurance Company of  
6 Washington under Policy number: 0186172516.<sup>14</sup>

7 b. The motor-vehicle accident in traffic caused P.W. to  
8 suffer an unspecified injury of the neck; strain of  
9 muscle, fascia and tendon at neck level; strain of  
10 muscle, fascia and tendon of lower back; dorsalgia;  
11 and strain of other muscles, fascia and tendons at  
12 shoulder and upper arm level, in unspecified arm.

13 c. P.W. was treated for these accident-related injuries  
14 on March 17, 2017, at The Everett Clinic, PLLC in  
15 Everett, WA, by physician assistant Jody Friday. At  
16 the office visit to the clinic, P.W was subjected to X-  
17 rays of the neck and lumbosacral spine areas.

---

<sup>14</sup> Defendant reported to CMS with the Claim Number: 3008268540, instead of with the Policy Number it later disclosed and the claim number missing last digits (3008268540-1-3).

1           d.     The accident caused the injuries set forth above.

2           e.     Treatment of P.W.'s neck and lumbosacral spine  
3                 areas was reasonable and necessary.

4           f.     P.W.'s medical provider billed the MAO Assignor  
5                 \$415.75 for the above accident-related treatment and  
6                 the MAO Assignor paid \$175.21 for treatment of  
7                 P.W.'s accident-related injuries. The diagnosis codes  
8                 contained within the medical bills from the medical  
9                 providers, relating to the accident-related treatments,  
10                are on the list of valid CMS codes. Moreover, the  
11                MAO Assignor paid for treatment of accident injuries  
12                that are either the same as, or similar to, the injuries  
13                that Farmers Insurance Company of Washington  
14                reported pursuant to Section 111.

15          g.     P.W. filed a third-party claim against G.C.'s bodily  
16                 injury policy, seeking as damages reimbursement of  
17                 medical expenses incurred by the MAO Assignor for  
18                 the accident-related injuries set forth above.

1           h.     Farmers entered into a settlement with P.W.<sup>15</sup> on an  
2                     unknown date and for an unknown amount, with  
3                     respect to this third-party bodily injury claim, arising  
4                     from the accident on March 17, 2017.

5           i.     In response to Plaintiff's attempts to Coordinate  
6                     Benefits, Farmers Insurance Company of  
7                     Washington delivered a check on June 29, 2023, in  
8                     the amount of \$415.75 to Series 15-09-321. Despite  
9                     Farmers Insurance Company of Washington issuing  
10                    payment in the amount Plaintiff demanded to resolve  
11                    the claim, Farmers Insurance Company of  
12                    Washington issued a stop payment on July 31, 2023  
13                    on the check.

14          j.     Farmers Insurance Company of Washington's  
15                     Section 111 report for P.W. admits the following  
16                     details about the claims:

17                i.   The settling party was Farmers Insurance

---

<sup>15</sup> Farmer Insurance Company of Washington reported to CMS insurance type: "Medicare Secondary, Other Liability Insurance is Primary.".

1 Company of Washington's insured.

2 ii. The accident caused P.W. to suffer dorsalgia  
3 and an unspecified injury to the neck. Further,  
4 the settlement agreement released P.W.'s  
5 claim for medical expenses relating to these  
6 injuries.

7 iii. P.W.'s Medicare coverage was secondary, and  
8 the liability insurance was primary.

9 iv. The applicable Plan name was Farmers  
10 Insurance.

11 92. The cross-referencing exercise Plaintiff undertook to identify the above  
12 examples is successful in identifying some unreimbursed conditional  
13 payments. However, the bulk of those payments remain hidden without  
14 cooperation by The Defendants. Since the Defendants have been unwilling to  
15 comply with its Congressionally-mandated obligations to determine when it is  
16 a primary plan under the MSP Act and ensure that it has reimbursed all  
17 conditional payments, this litigation is necessary to ensure current and future  
18 compliance with the MSP Act. There can be little doubt that the examples  
19 alleged above are merely the tip of the iceberg, and that thousands of other

1 instances exist in which the Defendants has accepted premiums to cover  
2 medical expenses arising out of automobile accidents but has chosen to let  
3 Medicare and MAOs pick up the tab.

4 93. The Defendants refusal to accept their Congressionally-mandated  
5 obligation to reimburse MAOs' conditional payments—instead pocketing  
6 premiums charged to cover the expenses it lets the MAOs pay—has led to this  
7 lawsuit.

8 **DEFENDANTS FAILED TO CONTEST THE**  
9 **REIMBURSEMENT CLAIM**  
10 **UNDER THE EXCLUSIVE ADMINISTRATIVE REVIEW PROCESS**  
11 **UNDER 42 U.S.C. §§ 405(G)-(H)**  
12

13 94. When a party wants to dispute a claim by an MA plan, it must do  
14 so through the exclusive review process outlined in 42 U.S.C. 405(g) and  
15 405(h). Section § 405(h) makes § 405(g), the Social Security program's judicial  
16 review provision, the sole avenue for judicial review of all claims arising under  
17 the Medicare Act.

18 95. When an MAO gets billed for medical expenses incurred by its  
19 beneficiary after an injury in an incident, the MAO determines: (1) whether

1 those expenses are covered under the health insurance policy; and, if so, (2) how  
2 much to pay. 42 C.F.R. § 422.566(b).

3 96. The MAO's initial decision regarding coverage for a Medicare  
4 enrollee's medical expenses is called an "organization determination," which  
5 includes any reimbursement determination made by an MAO with respect to  
6 payment made by an MAO for Medicare covered services. 42 C.F.R. §  
7 422.566(b)(3).

8 97. If any party wishes to challenge any aspect of an organization  
9 determination, that party must exhaust its administrative remedies by  
10 following a specific procedure for administrative appeal prescribed by the  
11 Medicare Act and its implementing regulations. 42 U.S.C. § 1395w–22(g); 42  
12 C.F.R. §§ 422.560–422.622.

13 98. Defendants failed to challenge MSP and the MAO Assignors'  
14 organization determination under the administrative process in 42 U.S.C.  
15 405(g), and as a result, it is foreclosed from disputing the reimbursement  
16 amounts in this lawsuit, as no party timely appealed the MAO Assignors'  
17 organization determination (i.e., reimbursement determination).

18 99. Thus, the amount Defendants owe is now fixed as to the universe  
19 of claims asserted in this action.

1                   **TOLLING OF THE STATUTE OF LIMITATIONS**

2                   **Equitable Estoppel**

3           100. Defendants have been under a continuous duty to identify and  
4   coordinate benefits with MAOs, including the MAO Assignor, and to provide  
5   proper notice to CMS of its primary payer status to ensure that conditional  
6   payments made on behalf of Medicare beneficiaries are reimbursed.

7           101. Defendants knowingly, affirmatively, and actively concealed or  
8   recklessly disregarded their obligations to the MAO Assignor and, therefore,  
9   are estopped from relying on any statute of limitations in defense of this action.

10                   **Fraudulent Concealment**

11          102. All applicable statutes of limitation have been tolled by  
12   Defendants' fraudulent concealment of its status as the primary payer for the  
13   MAO Assignor's Medicare beneficiary enrollees by: (1) intentionally failing to  
14   obtain the information needed to identify whether individuals with accident-  
15   related medical expenses covered by Defendants' policies are Medicare  
16   beneficiaries enrolled in Medicare Advantage Plans, (2) failing to properly  
17   submit Section 111 reports to CMS, and (3) failing to coordinate with MAOs  
18   or their assignors in order to evade having to reimburse conditional payments.  
19   Instead of complying with the requirements of the MSP Act and Section 111,

1 enacted to ensure that Medicare and now MAOs are secondary payers,  
2 Defendants have intentionally and fraudulently concealed its primary payer  
3 responsibility to avoid having to reimburse conditional payments.

4 103. Virtually all residents in the United States are covered under  
5 multiple policies of insurance. These policies include health, prescription, auto,  
6 and home insurance coverage. Although the enrollment process for these  
7 policies varies between carriers and policy types, certain features are common.

8 104. Auto insurers, including Defendants, ask numerous questions  
9 about the insured during policy underwriting such as the policy holder's name,  
10 address, date of birth, vehicle make and model, education level, employment  
11 information, driving history, vehicle registration, license information, accident  
12 history, and whether the insured resides with individuals of driving age.

13 105. Thus, when an insured makes a claim, the claim is then assigned  
14 to a claim handler to be processed through a standardized process. One of the  
15 steps in the process is to determine—for the first time—whether the claimant  
16 is Medicare eligible. Often, the claim adjuster will rely solely on responses to  
17 written forms sent to insureds, where the insureds will self-report whether they  
18 are Medicare eligible or will provide certain demographic information so the  
19 auto insurer can query Medicare's database. However, insureds are reluctant to

1 turn over information which results in Defendants' failure to identify and  
2 reimburse payments made by Medicare Advantage Organizations.

3 106. Moreover, throughout the life of a claim, the claim handler  
4 receives additional information from other third-party sources, such as  
5 examinations under oath, police records, medical bills, and the like.  
6 Defendants, however, have no process in place to extract information from  
7 those third-party sources and use that information to either query the Medicare  
8 eligibility database or to investigate further to learn of the insured's Part C  
9 provider. This too results in missed opportunities to identify and reimburse  
10 Medicare Advantage Organizations, including the MAO Assignor in this case.

11 107. Defendants know their current system is set up to result in large  
12 amounts of conditional payments being undetectable. They are undetectable  
13 because the MSP statute and implementing regulations rely on compliance by  
14 the auto insurer to make secondary payers, i.e., Medicare or MAOs, aware of  
15 the fact that someone has a primary payment responsibility. Indeed, Section  
16 111 and 42 C.F.R. § 411.25 were specifically designed so that auto insurers  
17 come forth with information to facilitate the coordination of benefits and  
18 reimbursement of payments owed to Medicare.

19 108. Defendants' choice not to change its system and processes to

1 result in accurate and complete coordination between itself and Medicare and  
2 MAOs amounts to fraudulent concealment that tolls the statute of limitations  
3 for all claims that Plaintiff or its MAO Assignor were unable to discover due  
4 to Defendant's fraud.

5 109. Defendants may register as an RRE for itself or for any direct  
6 subsidiary in its corporate structure.<sup>16</sup> Further, a parent company (regardless  
7 of whether it fits the formal definition of an RRE) may register as an RRE for  
8 any subsidiary in its corporate structure.<sup>17</sup> Accordingly, any of Defendants'  
9 subsidiaries may also be liable to Plaintiff, as illustrated by the labyrinthine  
10 organizational chart attached hereto as **Exhibit 1**.

11 110. As further evidence of Defendant's concealment of information,

---

<sup>16</sup> MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide, *available at* <https://www.cms.gov/Medicare/Coordinationof-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/NGHPTraining-Material/Downloads/Responsible-Reporting-Entity.pdf>; *see* CMS, Mandatory Insurer Reporting for Non-Group Health Plans (NGHP), <https://www.cms.gov/Medicare/Coordinationof-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/Overview.html>.

<sup>17</sup> MMSEA Section 111 Liability Insurance (Including Self-Insurance), No-Fault Insurance, and Workers' Compensation User Guide, *available at* <https://www.cms.gov/Medicare/Coordinationof-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Non-Group-Health-Plans/NGHPTraining-Material/Downloads/Responsible-Reporting-Entity.pdf>.

1 in violation of federal law, Plaintiff attempted to coordinate benefits solely on  
2 those claims that Plaintiff could identify from reports that Defendants made  
3 under Section 111. As described above and below, Plaintiff sent hundreds of  
4 letters to better understand whether Defendants fulfilled their obligation to  
5 reimburse Plaintiff's MAO Assignor. Instead of cooperating and providing  
6 information as the law requires, Defendants refused to provide information as  
7 discussed in paragraph 66, *supra*.

8 111. In fact, for the first-party and third-party examples above,  
9 Defendants ignored Plaintiff's requests to coordinate benefits—failing to  
10 provide any response whatsoever.

11 112. None of these reasons are valid reasons to refuse to provide  
12 information pursuant to Section 411.25. Instead, they reflect conduct that  
13 amounts to fraudulent concealment of information that Defendants are required  
14 to disclose and that concealment tolls the statute of limitations to the extent  
15 Plaintiff was unable to identify an actionable claim because of Defendants'  
16 conduct.

17 **Class Action Tolling**

18 113. Any applicable statute of limitations was tolled during the  
19 pendency of a prior class action.

114. Specifically, the claims made in this action were tolled by the pendency of *MAO-MSO Recovery II, LLC et al v. The Farmers Insurance Exchange et al.*, 2:17-cv-02522, in the Central District of California, filed on March 31, 2017.

115. Plaintiff seeks to opt out of any pending class action and is now entitled to bring all claims relating back to the filing of the above-mentioned class action.

## CAUSES OF ACTION

## COUNT I

**Private Cause of Action Under 42 U.S.C. § 1395y(b)(3)(A) for Settlement  
Claims**

**(Seeking the MAO Assignor's Unreimbursed Conditional Payments)**

116. Plaintiff re-alleges and incorporates herein by reference each of the allegations contained in the preceding paragraphs 1-111 as if fully set forth herein.

117. Plaintiff asserts a private cause of action pursuant to 42 U.S.C. § 1395y(b)(3)(A).

118. Defendants were a primary plan for the Settlement Claims.

1           119. Plaintiff's MAO Assignor, as part of providing Medicare benefits  
2     under the Medicare Advantage program, paid for accident-related items and  
3     services that were reasonable and necessary and which were also covered by a  
4     third-party policy that provided bodily injury coverage for accident-related  
5     medical expenses or by a first-party policy that provided UM or UIM coverage.

6           120. The MAO's Medicare beneficiaries made claims against  
7     Defendants' third-party policies to recover the medical expenses the MAO  
8     Assignor paid for items and services that were reasonable, necessary, and  
9     related to an accident. Defendants entered into settlements with the MAO  
10    Assignor's beneficiaries relating to accidents but failed to reimburse the MAO  
11    Assignor for accident-related medical expenses paid by the Assignor.

12          121. Defendants had a nondelegable duty to reimburse the MAO  
13    Assignor for payments it made for medical expenses related to an accident.  
14    Defendants are responsible for reimbursement of these accident-related  
15    medical expenses, even if it subsequently paid out the maximum benefits under  
16    the policies.

17          122. Defendants have and had a demonstrated responsibility to  
18    reimburse accident-related secondary payments relating to the Settlement  
19    Claims by failed to do so causing Plaintiff's MAO Assignor damages.

1 Defendants' responsibility to reimburse the MAO Assignor for its Settlement  
2 Claims conditional payments is demonstrated by the fact that Defendants  
3 entered into settlements with respect to the accidents with MAO Assignor's  
4 enrollees.

5 123. To the extent it was necessary, Defendants failed to  
6 administratively appeal the MAO Assignor's rights to reimbursement within  
7 the administrative remedies period. Defendants, therefore, are time-barred from  
8 challenging the propriety, reasonableness, and necessity of the amounts paid.

9 124. Defendants were required to timely reimburse the MAO Assignor  
10 for conditional payments of its Medicare beneficiaries' accident-related  
11 medical expenses.

12 125. Defendants derived substantial monetary benefit by placing the  
13 burden of financing medical treatments on the MAO Assignor in violation of  
14 the MSP Act and to the detriment of the Medicare program.

15 126. Plaintiff seeks to recoup only those medical items or services  
16 provided to the MAO Assignor's Medicare beneficiary enrollees that were  
17 related to motor vehicle accidents covered by Defendants' insurance policies.

18 127. Plaintiff brings this claim pursuant to 42 U.S.C. § 1395y(b)(3)(A),  
19 for reimbursement of its MAO Assignor's secondary payments and to recover

1 statutory double damages from Defendants for their failure to make appropriate  
2 and timely reimbursement of conditional payments for Medicare beneficiaries'  
3 accident-related medical expenses.

## 4 **COUNT II**

### 5 **Private Cause of Action Under 42 U.S.C. § 1395y(b)(3)(A) for First-Party**

#### 6 **Claims**

#### 7 **(Seeking the MAO Assignor's Unreimbursed Conditional Payments)**

8  
9 128. Plaintiff re-alleges and incorporates herein by reference each of  
10 the allegations contained in the preceding paragraphs 1-111 as if fully set forth  
11 herein.

12 129. Plaintiff asserts a private cause of action pursuant to 42 U.S.C. §  
13 1395y(b)(3)(A).

14 130. Defendants were the primary plan for the First-Party Claims.

15 131. Defendants have a demonstrated responsibility to reimburse  
16 accident-related secondary payments relating to the First-Party Claims but  
17 failed to do so.

18 132. With respect to the First Party Policy Claims, the MAO Assignor,  
19 while providing Medicare benefits under the Medicare Advantage program,

1 paid for accident-related medical items and services that were reasonable and  
2 necessary and that were also covered by no-fault, PIP, or MedPay policies  
3 issued by Defendants that provided medical coverage for accident-related  
4 medical expenses. The MAO Assignor's payments were conditional payments.

5 133. Defendants' responsibility to reimburse the MAO Assignor for its  
6 First Party Claims conditional payments is demonstrated by either the issuance  
7 of the policy providing coverage of the MAO Assignor's enrollees or by  
8 Defendants assuming ongoing responsibility for the medical expenses of the  
9 MAO Assignor's enrollee arising out of the accident.

10 134. Because Defendants were a primary payer—as established by the  
11 insurance policy or payment of one or more medical expenses or items—  
12 Defendants had a nondelegable duty with respect to the First Party Policy  
13 Claims to reimburse the MAO Assignor for accident-related medical expenses  
14 paid by the MAO Assignor

15 135. Defendants were required to timely reimburse the MAO Assignor  
16 for conditional payments of its Medicare beneficiaries' accident-related  
17 medical expenses.

18 136. The MAO Assignor suffered damages as a direct result of  
19 Defendants' failure to comply with its statutory and regulatory duties under the

1 MSP Act and the corresponding regulations within the Code of Federal  
2 Regulations.

3 137. Defendants derived substantial monetary benefit by placing the  
4 burden of financing medical treatments on the MAO Assignor in violation of  
5 the MSP Act and to the detriment of the Medicare program.

6 138. To the extent it was necessary, Defendants failed to  
7 administratively appeal the MAO Assignor's rights to reimbursement within  
8 the administrative remedies period. Defendants are, therefore, time-barred from  
9 challenging the propriety, reasonableness, and necessity of the amounts paid.

10 139. Plaintiff seeks to recoup only those medical items or services  
11 provided to the MAO Assignor's Medicare beneficiary enrollees that were  
12 related to motor vehicle accidents covered by Defendants' insurance policies.

13  
14  
15 **COUNT III**

16 **Breach of Contract for Failure to Pay Benefits for the Contractual**

17 **Claims**

18 **(Seeking the MAO Assignor's Unreimbursed Conditional Payments)**

19

1           140. Plaintiff re-alleges and incorporates herein by reference each of  
2 the allegations contained in the preceding paragraphs 1-111 as if fully set  
3 forth herein.

4           141. Plaintiff alleges certain claims here by way of subrogation.

5           142. At all material times, the MAO Assignor provided health  
6 insurance to Medicare beneficiaries, including those set forth in the examples  
7 above.

8           143. The MAO Assignor is subrogated to the right to recover from  
9 Defendants, in all instances in which Defendants are a primary plan, for  
10 Defendants' failure to make primary payment or reimbursement to the MAO  
11 Assignor for accident-related medical expenses.

12           144. The MAO Assignor paid for its enrolled Medicare beneficiaries'  
13 accident-related medical expenses in amounts to be proven at trial, pursuant to  
14 its agreements with CMS.

15           145. Defendants failed or refused to make primary payments of no-  
16 fault insurance benefits, or medical-payment benefits, as it was obligated to do.

17           146. Defendants' failure to pay or make timely reimbursement for the  
18 MAO Assignor's enrolled Medicare beneficiaries' accident-related medical  
19 expenses has caused the MAO Assignor damages, as set forth here, in amounts

1 to be proven at trial.

2  
3 147. To the extent necessary and not otherwise preempted by federal  
4 statute or regulation, Plaintiff complied with all applicable conditions  
5 precedent to the institution of this claim for reimbursement.

6 148. For the First Party Claims, including those where Defendants  
7 issued policies in states where no-fault coverage is mandatory, as well as states  
8 where first-party medical coverage is optional, Defendants had a contractual  
9 obligation to pay benefits under a first-party policy that covered medical  
10 expenses.

11 **COUNT IV**

12 **Fraudulent Concealment**

13  
14 149. Plaintiff re-alleges and incorporates herein by reference each of  
15 the allegations contained in the preceding paragraphs 1-111 as if fully set  
16 forth herein.

17 150. As described above, Plaintiff and its MAO Assignor's ability to  
18 identify and recover secondary payments is only as good as Defendants'  
19 compliance with its duty to report its primary payer status, as required by

1 federal law.

2 151. Based on the claims information reported to CMS under Section  
3 111, Plaintiff identified instances in which Defendants failed to properly  
4 reimburse on reported claims.

5 152. In addition, on information and belief, Plaintiff alleges  
6 Defendants have not and cannot report all claims because it deliberately  
7 designed and operates a claim adjusting system that results in repeated,  
8 systematic failures to disclose its primary payer status for all first party policy  
9 claims and settlement claims as is its duty under the MSP Act and its  
10 implementing regulations.

11 153. For all First Party Policy claims and Settlement claims,  
12 Defendants' duty is to disclose information about its primary payer status to  
13 CMS, for the benefit of Medicare and, by extension, MAOs such as Plaintiff's  
14 MAO Assignor.

15 154. Defendants' primary payer status and the fact it acted as the first-  
16 party insurer or settled a liability claim under a third-party policy are pieces of  
17 information known and/or accessible only to Defendants, because they  
18 possessed exclusive and/or superior knowledge as to such facts. Moreover,  
19 Defendants knew these facts were not known to or reasonably discoverable by

1 Plaintiff or its MAO Assignor.

2 155. By virtue of its repeated, systematic failure to report its primary  
3 payer status when it acted as the first-party insurer or settled a liability claim  
4 under a third-party policy, Defendants knowingly and/or recklessly concealed  
5 this information breaching the duty prescribed to it under the MSP Act and its  
6 implementing regulations.

7 156. Defendants' knowing and/or reckless concealment of its primary  
8 payer status by means of failure to report under Section 111 is a breach of duty  
9 separate and distinct from its failure to properly reimburse under the MSP Act  
10 and its implementing regulations.

11 157. Plaintiff and its MAO assignor were unaware of the concealed  
12 material facts relating to Defendants' primary payer status for unreported First  
13 Party Policy and Settlement Claims and Plaintiff and its MAO Assignor would  
14 not have acted as they did if they had known Defendants were a primary payer  
15 for the unreported First Party Policy and Settlement Claims.

16 158. Specifically, Plaintiff's MAO Assignor would not have made any  
17 secondary payments if Defendants had properly disclosed primary payer status  
18 before Plaintiff's MAO Assignor paid. Moreover, Plaintiff would have timely  
19 pursued reimbursement against Defendants, through issuance of a demand

1 letter, had Defendants not concealed its primary payer status from Plaintiff and  
2 its MAO Assignor. Plaintiff through its MAO Assignor justifiably relied on the  
3 absence of a Section 111 report when making secondary payments on the  
4 unreported first party policy and settlement claims.

5 159. Because the omission of the material fact that Defendants were a  
6 primary payer for the unreported First Party Policy and Settlement Claims,  
7 Plaintiff and its MAO Assignor sustained damages when the MAO Assignor  
8 paid for items and services that were the responsibility of Defendants. Had  
9 Plaintiff and its MAO Assignor known of the facts Defendants knowingly  
10 and/or recklessly concealed, Plaintiff's MAO Assignor would not have paid for  
11 items and services that were the responsibility of Defendants. In addition, even  
12 in instances where Plaintiff's MAO Assignor made such payments, Plaintiff  
13 would have timely pursued reimbursement against Defendants.

## 14 COUNT V

### 15 Declaratory Relief Pursuant to 28 U.S.C. § 2201

#### 16 (As Related to the MAO Assignor's Unreimbursed Payments)

17  
18 160. Plaintiff re-alleges and incorporates by reference each of the  
19 allegations contained in the preceding paragraphs 1-111 as if fully set forth

1 here.

2 161. Plaintiff alleges that as part of providing Medicare benefits under  
3 the Medicare Advantage program, Plaintiff's assignor paid for items and  
4 services which were also covered by no-fault, personal injury protection, or  
5 medical payments policies issued by Defendants.

6 162. Defendants entered into settlements with beneficiaries relating to  
7 accidents but failed to reimburse Plaintiff's assignor for accident-related  
8 medical expenses paid by Plaintiff's assignor. As primary payers, Defendants  
9 had a nondelegable duty to reimburse conditional payments advanced by  
10 Medicare participants for accident-related medical services rendered to covered  
11 persons. Defendants are liable for reimbursement of these accident-related  
12 medical expenses, even if they subsequently paid out the maximum benefits  
13 under the policies.

14 163. Defendants were required to timely reimburse Plaintiff's assignor  
15 for conditional payments made on behalf of beneficiaries' accident-related  
16 medical expenses.

17 164. An actual, present, and justiciable controversy has arisen between  
18 Plaintiff and Defendants concerning their obligation to reimburse Plaintiff's  
19 assignor.

1           165. Plaintiff seeks a declaratory Judgment from this Court establishing  
2   that Defendants have a historical, present, and continuing duty to reimburse  
3   Plaintiff's assignor for payments made on behalf of beneficiaries' accident-  
4   related medical expenses. Plaintiff also seeks a declaration of what amounts  
5   are due and owing by Defendants to Plaintiff's assignor.

6           166. A determination of what amounts are owed by Defendants to  
7   Plaintiff's assignor is complicated and difficult.

8           167. A coordination-of-benefits process requires plans to share  
9   information between the primary payer and secondary plan and to act in good  
10   faith.

11          168. The Code of Federal Regulations defines the coordination of  
12   benefits system as a "coordination of benefits transaction."<sup>18</sup>

13          169. The coordination of benefits transaction involves the exchange of  
14   thousands of claims data and data points between the parties to determine  
15   overlapping instances where Plaintiff's assignor made payment of medical  
16   items and services on behalf of a Medicare beneficiary who was entitled to the  
17   benefit of insurance coverage provided by the Defendants. This includes not

---

<sup>18</sup> The "coordination of benefits transaction" is the transmission from any entity to a health plan for the purpose of determining the relative payment responsibilities of the health plan, of either of the following for health care: (a) claims and (b) payment information. 45 CFR § 162.1801.

1 only instances in which a Medicare beneficiary was directly insured by  
2 Defendants, but also instances in which a Medicare beneficiary was injured by  
3 Defendants' policyholder.

4 170. The exchange of claims data would need to be done by extracting  
5 and producing certain data fields from Defendants' and Plaintiff's databases by  
6 using demographic identifiers, such as Social Security Number ("SSN"),  
7 Health Insurance Claim Number ("HICN"),<sup>19</sup> date of birth, sex, and address.  
8 Beneficiary matching pinpoints the number of relevant insureds and simplifies  
9 the process of identifying reimbursable claims, which is done by matching the  
10 date of loss (for Defendants), with dates of payment (for Plaintiff), and then  
11 discovering what Defendants reimbursed (if anything), and to whom.

12  
13 171. Given the size of the claims and data points being exchanged  
14 between the parties, the coordination of benefits transaction is complex.

15 172. Thus, Plaintiff lacks an adequate legal remedy to obtain the  
16 requested information.

---

<sup>19</sup> Also known as a Medicare Beneficiary Identifier ("MBI").

1 **JURY TRIAL DEMAND**

2 Plaintiff demands a trial by jury on all of the triable issues within this  
3 pleading.

4 **PRAYER FOR RELIEF**

5 WHEREFORE, Plaintiff seeks a judgment against Defendants granting  
6 the following relief:

7 i. A judgment for any secondary payments made by Plaintiff's MAO  
8 Assignor which Defendants should have paid based on its primary payer status  
9 for First Party Policy Claims and Settlement Claims;

10 ii. A judgment awarding double damages for those amounts to which  
11 Plaintiff is entitled to reimbursement as allowed under 42 U.S.C. §  
12 1395y(b)(3)(A);

13 iii. In the alternative, a declaratory judgment for the relief requested  
14 in Count V;

15 iv. A judgment awarding Plaintiff pre-judgment and post-judgment  
16 interest;

17 v. Attorneys' fees as may be allowed under any applicable law;

18 vi. Tolling any applicable statute of limitations for First Party Policy  
19 Claims and Settlement Claims Defendants were under a duty to report pursuant

1 to Section 111 but concealed by means of its failure to properly report; and

2       vii. A judgment awarding Plaintiff such other and further relief as the

3 Court deems just and proper under the circumstances.

4 Dated: October 15, 2023

5  
6 Respectfully Submitted:

7 /s/ Alex R. Straus

8 Alex R. Straus, Esq.

9 CA Bar No.: 321366

10 **MILBERG COLEMAN BRYSON**

11 **PHILLIPS GROSSMAN, PLLC**

12 280 S. Beverly Drive, Penthouse

13 Beverly Hills, California 90212

14 Tel.: (919) 600-5000

15 Fax: (919) 600-5035

16 Primary Email: [astraus@milberg.com](mailto:astraus@milberg.com)

17 Secondary Email: [ralves@milberg.com](mailto:ralves@milberg.com)

18